			1 - For Stata Registrar	State of Maryland		artment of H			iene	004	03001		
	Dhysici	20	Decedent's Name (First, Middle, Last)	.0				2. Date of Deat	th Day	Year	3. Time of Death		
	Physici /Medic		(°ar/05	13.		Ka	mos	tebura	ry 3	2004	1245 PM		
10 m	Examin	er	4a. Facility Name (If not institution, give :	/	- 01	4b. City, Town, or	Location of Deal	th Cr . > (/	4c. County		N/A		
	Funeral		5. Social Security Number 6. Sex	2K11US / +USP 1	THL ast birthday)	DALT IV If Under 1 Year	If Under 24 Hrs	8. Date of Birth		9. Birthpl	lace (State or Foreign		
п	Director		225-49-0949	( <sup>M 2□ F</sup> 43	Yrs.	Months Days	Hours Min	AUG. 23	,1960	Coun	MEXICO		
	p ,		Usual Residence of Decedent  10a. State 10b. County	100 Cib	, Town or Lo	antion				10	0d. Inside City Limits		
	fanyla e hov	ō	MD N/A			TIMORE				'	1 No 2 No		
	28a-	Director	10e. Street and Number	1	DAL	10f. Zip Code		1	0g. Citizen of	What Coun	itry?		
	feath with the Marylan ne 23a or 28a-f ehow mart be notified at	i Die	100 N. ROSE STREE	T			21231				MEXICO		
	ter deati	Funeral		12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	Specify Yes or No-		ce - America			
20	172 hours after death with the Maryland *naturel; or Items 23a or 28a-f show cilcal Examinar must be notified at	by Fu	t X Never Married 2 ☐ Married	1 □ Yes 2 📉 No If Yes, Give Year or Dates:	ĺ	1∭XYes 2□No		1EXICAN	Specif		WHITE		
215-0036	ture!		3 Widowed 4 Divorced		16a Decer	dent's Usual Occupa			16b. Kind of B	tusiness/inc			
<u>ر</u> ب	nin 72 In nat	plet	(Specify only highest grade		(Give	kind of work done of DO NOT use retired	furing most of wo	nking	TOD. INITIO OF E	03110331110			
7	giene. er than ", tre Mac	Completed	Elementary/Secondary (0-12)	College (1-401 3+)	FOREN	1AN			CONSTR	RUCTIO	N COMPANY		
and	be filed ital Hygi ed other event, II	Be	17. Father's Name (First, Middle, Last)		D.0110.0			me (First, Middle, I	Maiden Sumar				
	should nd Men marke imarke	Jo	BERNARDINO	an Reint	RAMOS		IRMA		- Ch T				
Mary	Cl a = =		19a. Informant's Name/Relationship (Ty) NICOLAS H. RAMOS										
ē,		Ì	20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of natory or other place							
aitimore,	. Peges Iment of tant: If i jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		SA CEMETE		/2004	COAHUIL	A. ME	XICO		
<u>a</u>	armit. Pe apertmen aportant: vy injury	Ì	21. Signature of Funeral Service License			. Name and Addres							
מ	<b>20</b> = 9 9		Edward (1)	MM -						LLE,			
	_ '7		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	e cause on each line.				c or respiratory arre	est,		Interval Between Onset and Death		
1	?hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Kliebsie	lla	Urosef	Sis				four days		
	Examiner			Due to (or as a consequ	ence or):	290				ALICIA Town, State, Zip Code) STOWN, MD 21136 ation - City or Town, State  JILA, MEXICO & BROS., INC. SVILLE, MD 21208 Approximate Interval Between			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):						out oney		
	executed in and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
8/60,	pri pe		resulting in death, Last	Due to (or as a consequ	ence of):								
289	certificate nding physise as the	edicai		l									
XOX	onding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar		T			23d. Da	ate of delive	ry		
	w requires that the death certific; been signed by the attending ph should be detached for use as t	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Mo	onth	Day Year		
7 O	d by the	Phy	9 Unknown		10.5			20 Didah		A-16 A A6-	e cause of death?		
ďs,	requires that the leen signed by th hould be detache	l by	Part II. Other significant conditions con	induting to death but not resu	iting in the ur	nderlying cause give	n in Paπ i,	1 □ Ye	5-0		ably 4 Dunknown		
•	w requ	etec	Vatation	14,1500	C 100 !	105	Coma	24a. Was a		Ware autor	psy findings available		
ě	he law e has b age 2 sh	Completed	NOU- VEIDII	HAPER	Sm	3/01	0119	autops perform	ned?	prior to con death?	npletion of cause of		
VITAI H	an: T	0	25. Was case referred to medical				26. Place of De	1 ☐ Yes 2 ath (Check only on		1 🗆 Yes	2 NAG		
0	hysici his ce I direc	To B	examiner?	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe	\C	dome 5 ☐ Reside		ner (Specify	)		
ב	Ing P	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho	w injury occur	red			
DIVISION	death death ctor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ma farm etr		fes 2 □ No	28f. Location (St.	reat and Numi	her or Rura	I Poute Number		
2	after after Direct	Certification:	4 Homicide determined	building, etc. (Specify	)	eet, ractory, office		City or Town		yer or marar	Thousands,		
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 or	calC	29a. Certifier 1 Scertifying Phys	sician: To the best of my know	viedge, death	occurred at the tim	e, date and place	e, and due to the ca	ause(s) and m	anner as st	ated.		
	the H iin 24 the Fi	ledical	one)	ner: On the basis of examinati and manner stated	on and/or in								
	To To	X	29b. Signature and title of certifier	20+1/1		29c. License			9d. Date signe				
	į,		Aushiel V	· all)	11)		5586	5 +	rebur	ary	3 2004		
	X		30. Name and address of person who co			orth Wa	IFP C+	root D	altimore	re. Mi	21287		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure		1111 111		~(1)11410		0.01		
	Registr	ar	FEB 0 4 2004	1	1								

/Medi	ian	Decedent's Name (First, Middle			C. 15	THOCIL			2. Date of De Month	Day		.	3. Time of Death
		4a. Facility Name (If not institution		treet and number)	18			or Location of De	ゴトル	2 G	200	_	1010 4
xamii	ier	Northwest Ho	-								Balti		•
neral		5. Social Security Number	6. Sex	7. Ag	e (In yrs.	M	Under 1 Year onths Days		s. 8. Date of Bir (Month, Da	rth .	9.	Birthpla Countr	ice (State or Foreig
tor		243-42-1634		M 2UF .	70	Yrs.				9	33	_NC	
		Usuel Residence of Decedent  10a. State 10b. County	/		10c. Cit	y, Town or Locati	on					10	d. Inside City Limit
ence.	tor	MD N	A BA	LTIMORE	Ва	ltimor	e						1 X Yes 2 N
	Director	10e. Street and Number			1	1	Of. Zip Code			10g. Cit	izen of What	Countr	ry?
		6220 Robin H						1207			U.S.		
	une	11. Marital Status		2. Was Decedent Armed Forces?		.S. 13. Was	Decedent of is, specify Cul	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No arto Rican, etc.)	o- )	14. Race - A Black, W		
	by Funeral	1 ☐ Never Married 2 ☐ Mar 3 🖾 Widowed 4 ☐ Divorced		1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	40	10	Yes 2X No	Specify:			Specify:	в	lack
	ted	15. Deceder	nt's Educ	ation		16a. Decedent	's Usual Occu	pation		16b. K	ind of Busine	ess/Indu	ıstry
	Completed	(Specify only highe Elementary/Secondary (0-12)	sst grade	College (1-4or 5	i+)	life. DO	NOT use retir	e during most of we ed)	ronking				
	Con	8th grade		na		Truc	k Driv			Se	lf Em	plo	yed
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ė		21. Signature of Funeral Service		e 01 -				785 of Facility West	2/11/0	4 C	rerpe		10
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30		28a. Part   Enter the disease,	e complic	cations that causes	t the election								
	_	shock, or heart failure. List	t only on	e cause on each li	1 (ne dee() 10.	h. Do not enter th	ne mode of dy	ing, such as cardi	ac or respiratory a	rrest,		1	Approximate Interval Between
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Year Physician DAN CLARENCE STEMMER 315 2004 1140 AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MUHI- Medica 5. Social Security Number 6. Se BALTIMORE Nochol tex. 6. Sex 100 M 2□ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5-22-193 Birthplace (State or Foreign Country) **Funeral** Days 127-18-2116 Usuel Residence of Decedent P. Yrs. Months Hours Min Director 10a. Stete 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Haaith and Mentel Hygiene. Important: If item 27 is marked other than "natursi", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at 10d. Inside City Limits 1 Yes 2 No Director ORI New 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U,S.
Armed Forces?
1 If Yes 2 □ No
17 %, Give
Year or Per USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No δ Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1/4or 5+) (2 nameer mineering 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden (Sulname) Be Stemmer sertrude. tinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stemmer ωρ, 20b. Place of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) Date EVANS FLUERAL CHOPEL-BELAIR 2-1-04 FOREST HILL MD 22. Name and Address of Facility
23.25 YOLK RA, TIMONIUM MD 21093 21. Signature of Funeral Service License PEACEPUL ALTERNATIVES FUNERAL-CREMATION CENTER 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical ACCUDENT CEREBROUASCULAR Examiner Due to (or as a consequence of): Examiner The law requiras that the daath certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence oil. Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was cese referred to medicel examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Hospitel: Other: All Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ENatural 4 hours after death.

-unerel Director: Aft
ely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) H.D 10053150 FEB 154 2004 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 201-109 BACH RIVERNECL RD BACTIMORE GUPTA SHAKUNMAL 31. Date filed (Month, Dey, Year) 15515 DY 3# Registrer's Signature State FEB 0 4 2004 Registrar

			1 - For State Registrar	State of M	arylar		artmen rtificat					giene Reg. No.	200	14 (	)3(	004
	Physici	an	1. Decedent's Name (First, Middle, La:	SLEEN	100	1					2. Date of De Month	ath Day	Ye		Time of	Death
	/Medi					-	Al- Olh	<b>T</b>	1	-1 D11	JANUARY	30	200	7	13.0	77 M
	Examir	er	4a. Fecility Name (If not institution, give UNIVERSITY OF MAR)			SNTR	BALT		Location 6	or Death		46. (	County of E	Jean		
	Funeral		5. Social Security Number 6. S			last birthday)	If Under	1 Year	If Under		8. Date of Bir	th	9.	Birthplece	(Stete o	or Foreign
	Director		220-36-7000	[X]M 2□F	62	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 2/7/194	1	ВА	Country) LTIMO	RE,	MD
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	cation							10d. le	nside C	ity Limits
	aho	'n	MD		100.0	BALTIN		ידיי <b>ע</b>								2 No
	28a-1	ect	10e. Street and Number			DALITI	10f. Zip					10g. Citiz	en of Wha	t Country?		
	3e or	ā	1144 NANTICOKE S	TREET				2123	30			1	U.S.A			
	72 hours after deeth with the Maryland natural', or Items 23a or 28a-f ahow disal Examiner must be rodified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U	J.S. 13.	Was Deced	ient of Hi	spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	- 1		American Ir White, etc.	ndian,	
98	or Ite	y Fu	1 Never Married 2 Married	1 □ Yes XXX tf Yes, Give		1	1 □ Yes 2				, , , , , , , , , , , , , , , , , , , ,		Specify:	WHIT	E	
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ylai		오	GEORGE SLEEMAN							_	BELL					
Maryland	2 sh and is m		19a. Informant's Name/Relationship (	•	mpp.						al Route Numb	-				7.0
	s 1 and if Health Itam 27 other tr		SUSAN MARIE YOUN  20a. Method of Disposition	G - DAUGH		L∠5 Place of Dispo			RY AV	A	, HAVRE			, MD y or Town, :		/8
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	Physician		Immediate Cause (Final disease or condition	DUODS	NAI	. (7)	CFR							Ons	et and I ₩ ₹£	Death
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	ed sit	ulne	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a consec	quence or):										
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Box	leath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom- 1 ☐ Live birth			]Ectopic pr	egnancy				2	3d. Date of	delivery Day		Year
_	the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	at time of	death 5	Other (sp	ecity)					WORKIT	Day		1001
P.O.	that the de ad by the detached		Part II. Other significant conditions of	ontributing to death	but not re	sulting in the u	nderlyina c	ause give	en in Part I	l.	23e. Did t	obacco us	e contribu	te to the ca	use of c	death?
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00	w requir	Completed									24a. Was	an	24b. Wer	e autopsy f	indings	available
Re	The lav	dwo										med?	prior deat 1 🔲			ause of
Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical						26. Place	e of Deal	1 ☐ Yes		10	163 2	140	
<b>/</b>	Physician: this certific al director,	To B	examiner? 1 □ Yes 2⊠ No	Hospital: 1 Alnpat	ient 2	] ER/Outpatier	nt 3 DC	Oth	er: 4 🗌 Nu	ursing Ho	ome 5 Resi	dence 6	Other (	Specify)		
n of	ding Pt h. Atter th funeral		27. Manner of Death  1. SNatural 5 Pending	28a. Date of Inj (Month, D	ury ay Ye <i>ar)</i>	28b. Time o Injury	f 2	8c. Injun Worl			28d. Describe I	now injury	occurred			
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Σ	l or Attendater deatl Director:	artifi	4 Homicide determined	28e. Ptace of Ir building, e	itc. (Speci	nome, farm, sti ify)	reet, factory	, office			28f. Location (: City or Tox		rivumber o	ir Hurai Hol	ite ivum	Der,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier 1PC Certifying PI	ysician: To the bes	t of my kn	owledge, deat	h occurred	at the tim	ne, date ar	nd place.	and due to the	cause(s)	and manne	er as stated		
	To the Hospita within 24 hours To the Funeral completely filled	edical		niner: On the basis and manner s	of examin											;)
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	W		30. Name and address of person who					m -							777	
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	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regis	irai s sign	- Francisco	3000									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2:50PM January MILDRED **SCHULMAN** 7004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Of Baltimore Baltimore Dinau If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) SEPT. 20, 1921 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2₩F 216-10-9503 82 Director PA Usuel Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ral', or items 23e or 28a-f ehov Examiner must be civiling at 1 ☐ Yes 2 ☐ No BALTIMORE Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4204 OLD MILFORD MILL ROAD 21208 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 ☐ Widowed 4 🛣 Divorced WHITE Year or Dates: \*natural', the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done duril life. DO NOT use retired) CLOTHING Elementary/Secondary (0-12) r then College (1-4or 5+) OFFICE MANAGER MEN'S & WOMEN'S 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be marked TOBACK **ESTHER** ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 LONGHORN CRESCENT - ROCKVILLE, MD 20850 JOEL LEVIN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) SHAAREI ZION CEMETERY 2/2/2004 ROSEDALE, MD 21. Signature of Funeral Service Li 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one case on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumonia disease or condition resulting in death) day /Medical Due o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 1 Yes 2 No ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 (ZN)atural al or Attendin s after death. Il Director: Af 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES- 000 30 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore Portera Singi MA 31. Date filed (Month, Day, Year)

EER 0 4 2004 32, Registrar's Signature State 0 Registrar

ase	Type or Print in Black indelible ink.	Ensure All Copies Are Legi
	State of Maniford / Department of He	calth and Mental Hygiene

DAP	)		1 - For State Registrar	State of Maryland / D		rtment of H		-	giene Reg. No. 2 (	004	03006
F	Physici	an	1. Decedent's Name (First, Middle, Last)  LOUIS Henry	y Smith				2. Date of Dea	Day 2,200	Year 1	3. Time of Death 9:30 a M
,	/Medio Examin		4e. Facility Name (If not institution, give state) 125 NORTH GLOVER S	treet and number)		4b. City, Town, or BALTIMOR				y of Death	9:30 a
	uneral rector		5. Social Security Number 212-14-8614  Usual Residence of Decedent	M 2□F 7. Age (In yrs. last bin	thday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	Irs. 8. Date of Birt (Month, Da DEC . 1	7,1921	9. Birthp Coun Mar	lace (State or Foreign try) yland
e Maryland	Sa-f show diffied at	ctor	Maryland n/a	10c. City, Town		more					0d. Inside City Limits 1    Yes 2 No
with th	3a or 2	I Director	10e. Street and Number 125 North Glover	Street		10f. Zip Code	21224		10g. Citizen of Unit	what Coun ed St	
O Z IZ I 3-0030 filed within 72 hours after death with the Maryland Hygiene.	important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at 2008.	by Funerai		2. Was Decedent Ever in U.S. Amed Forces? 1 Al Yes 2 □ No If Yes, Give Year or Dates: WWII	1	Vas Decedent of H Yes, specify Cuba	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	- 14. Ra Bla Speci	ce - Americ ick, White, fy: W	
vithin 72 ho	han "natur e Medical	Completed	15. Decedent's Educ (Specify only highest grade		Deced (Give life. D	ent's Usual Occupa kind of work done of NOT use retired Painter	ation during most of t	working	16b. Kind of E	Business/Ind	•
Vicinity of the vivid be fitted vivid be fitted vividial Hygie	ked other tic event, the	To Be Co	17. Father's Name (First, Middle, Last)  Joseph Smith			Tarifeet	18. Mother's Mar	Name (First, Middle, Y Mi			Oldi
, INICAL YICA and 2 should saith and Men	n 27 is mar er traumat		19a. Informant's Name/Relationship (Type Mr. Tyrone E. Smit			g Address (Street a		Rural Route Number Fallston			<sup>Code)</sup> 21047
partification permit. Pages 1.8	ant: If iten iury or oth		20a. Method of Disposition 1	emoval from State Most Ho	y, crem oly F	sition (Name of latory or other plac Redeemer Ce	m. Feb	Date 0.5,2004	Balti	more,	MD
permit Depart	any in		21. Signature of Funeral Service License	Michael E. Canapp		Name and Addres • eonard J			305 Har altimor		Road 21214
/Me	sician edical miner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not be cause on each line.  Attle voscile ro	tic		,	liac or respiratory ar	rest,		Approximate Interval Between Onset and Death
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w requires that	s been signed b	þ	Part II. Other significant conditions cont	ributing to death but not resulting in	the un	derlying cause give	an in Part I.	T I			e cause of death? ably 4 XUnknown
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e g	To the Funerel Diractor: After this certificate his completely filled in by the funeral director, page	ertification: T	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation		lime of	28c. Injury Work M 1 []		28d. Describe h			
DIVIS bitel or Att urs after de	To the Funerel Diractor: A completely filled in by the fu	0	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)				28f. Location (S City or Tow	n, State)		
he Hosp	he Fune cletely fi	edical	29a. Certifier 1 ☐ Certifying Physic (Check only one)	er: On the best of my knowledge er: On the basis of examination and and manner stated.	i, death d/or inv	occurred at the time estigation, in my or	ie, date and pla pinion, death oc	ace, and due to the o courred at the time, o	ause(s) and m date and place,	anner as sta and due to	ated. the cause(s)
To t	To 1	×	29b. Signature and title of certifier  Roy Line				o number	1	PBUARY		
6+	1		30. Name and address of person who con ZABIHLLAH	npleted cause of death (Item 23a) (	Type, i		Street	t, Baltimo	ore, Ma	ryland	1 21201

Registrar

FEB 0 4 2004

			_ FOI	partment of Health and Me ertificate of Death	ental Hygie	_ 2004	03007
		=6	Decedent's Name (First, Middle, Last)		2. Date of Death	5	3. Time of Death
	Physici		Ralph Frank	Tropea Jr. F	Month eb 2,20	Day Year	5:33 p M
>	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Examin	E	1453 Maryland Ave	Severn		Anne Aru	nde 1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		3. Date of Birth		ice (State or Foreign
11	Director		203-20-9842 XXM 2□F 75 Yrs.	Months Days Hours Min.	B. Date of Birth (Month, Day, Ye (Ar 3, 19	Penns	ylvania
Al.	gf		Usual Residence of Decedent				
	/land		10a. State 10b. County 10c. City, Town or I	ocation		100	d. Inside City Limits
	Man	tor	MD Anne Arundel Severn				1 ☐ Yes 2√ No
	28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Countr	y?
	With Man		1453 Maryland Ave	21144		USA	
	eath s 2;	Funeral		. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puento R	rfv Yes or No-	14. Race - America	n Indian,
	Hen Hen	'n.	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puento R	ican, etc.)	Black, White, et	
50	rs af	by	1 □ Never Married 2 M Married 1 M □ Yes 2 □ No ff Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 1946-69	1 ☐ Yes 2 X No Specify:		Specify: Whi	tе
ş	tura Kura	ed		edent's Usual Occupation	168	b. Kind of Business/Indu	ıstrv
2	n 72	Completed	(Specify only highest grade completed) (Giv	re kind of work done during most of working DO NOT use retired)	7		,
2	that t	m C	Elementary/Secondary (0-12) College (1-4or 5+) 1 2 Set	rgeant	İ	U.S. Army	
71 12	be filed within 72 hours after death with the Maryland thygiene. A thygiene. do ther than "natural", or items 23a or 28a-f ehow do there than "natural", or items 23a or 28a-f ehow event, the Madical Examiner must be notified at		17. Father's Name (First, Middle, Last)	18. Mother's Name (	First, Middle, Mai		
a	2 should be filed volume and Mental Hygis is marked other traumatic event, in	o Be	Ralph Frank Tropea, Sr.	Elizabet	h Angelo	)	
<u>-</u>	should nd Men marke umatic	은		ling Address (Street and Number or Rural			Code)
	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic. anges.			B Maryland Avenue, S			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	1 and 2 Health em 27 I		20a. Method of Disposition 20b. Place of Disp			. Location - City or Tow	m State
Baltimore,	Pages net of I int: If ite		1 ☐ Burial ②CTCremation 3 ☐ Removal from State	ematory or other place)			
Ē	permit. Pag Department Important: any injury c		`4 □Donation 5 □Other (Specify) Metro Ci		)04 Ba	altimore, M	D
ä	permit. Departr Imports any inje		21. Signature of Euneral I rvice Licensee	22. Name and Address of Facility Hardesty Funeral F	lome P.A.		
	90E = 9		Dall I wil	12 Ridgely Avenue,	Annapol	is, MD 214	01
*			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest,		Approximate nterval Between
<b>9</b> F	Physician		Immediate Cause (Final disease or condition	end Dresser 13	LAZZ	enic.	Onset and Death
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):				
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o,	exector an arrial-to		resulting in death) Last Due to (or as a consequence of):				
8760	cate be executed bhysician and the burial-transit	dical	d				
9	tificat ig phy as th	edi	Andrew Marie Control of the Control				
Вох	dir	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery	,
ň	death e atten	cla	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		Month D	ay Year
o.	the c y the scheo	Jys	9 ☐ Unknown			:	
٠	The law requires that the de ste has been signed by the a page 2 should be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	cause of death?
ds	uires sign	q p	Vascular dements a		1 🗆 Yes	2 No 3 Probat	bly 4 Unknown
Ö	w require been sig should b	ete			24a. Was an	24h Mara autana	ny findrana available
Records,	e lav has je 2:	Completed by			autopsy performed	prior to comp death?	sy findings available pletion of cause of
		ပိ			1 □ Yes 2 ☑		D <sub>No</sub>
Vital	cian ertifi ector	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
5	Physi this o	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		1100000	e 6 ☐Other (Specify)	
2	ng P	on:	27. Mann or of Death  1 → Natural 5 □ Pending  28a. Date of Injury (Month, Day Year)  28b. Time Injury	Work?	ld. Describe how i	injury occurred	
<u> </u>	endi eath. or: A or: A	atl	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 Tyes 2 No			
Division of	il or Attending P after death. I Director: After t d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	street, factory, office	If. Location (Stree City or Town, S	t and Number or Rural I tate)	Route Number,
	rs af	Ç		<u> </u>			
	dosp hom une une sly fil	edical	29a. Certifier  (Check only  1 Certifying Physicien: To the best of my knowledge, dea  (Check only  2 Medical Exeminer: On the basis of examination and/or	ath occurred at the time, date and place, are	d due to the caus	e(s) and manner as stat	led.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		and manner stated.	and a second sec		and place; and due to t	
	To To Foo	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Da	ay, Year)
t	50		1/ / wolld	1151857	to.	bruen T.	2004
	70		Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	- / 1	(1)	11001
	0		Kusell V. Delmen 305 Hos	situl of we	/en By	m. / he/ - L	106/
	Sta		31. Date filed (Month, Sely, Year) 32. Registrer's Signature	1 10 -		,-	
	Registi	ar	TED 0 4 2004 Pagence 15	MODELLE !			

	-	. >	1 - For State Registrar	State of Maryland /	Department of Health and Certificate of Death	Mental Hygiene	2006 02000
	Physici /Medic		1. Decedent's Name (First, Middle, Last		Thornton	2. Date of Death Month Da	Year 9:00 AM
	Examin Funeral Director	er	4e. Facility Name (If not institution, give  5. Social Security Number 16. Se  Usual Residence of Decedent	pkins Hopita	4b. City, Town, or Location of Deal  About 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	City	9. Birth hace (State or Foreign
	death with the Maryland me 23e or 28e-f show	ctor	10a. State 10b. County	10c. eny. T	White Location Lei MOCE		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	a 23a or 28	Funeral Director	10e. Street and Number	Vaca AVE.	10f. Zip Gode 21/2014	6	yzen of What Country?
9036	nours after de urel', or Item	by	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:		14. Race - American Indian, Black, White, etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other than "neturel", or Itema 23a or 28a-f show other traumatic event, Ite Modical Exemitest, and be notified as	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	ia. Decedent's Usual Occupation (Give kind of work done during most of wo life / DONOT use retired)	rking 18b. K	ASTRUCTION
Maryland	2 should be filed and Mental Hygis Is marked other aumatic avent, III	To Be	17 Fither's Name (First, Middle Hast) 12 A Littlemant's Name/Relatidoship (7)	CUTON 1	COKE	me (First, Middle Maider NE NO ural Frouls Number, Sitt	Town, State Zip 2020
	0 0		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ F	20b, Pr	of Disposi on (Name, of tery, premaiory orgother place)		oycli Diby Town, Sidle
Baltimore,	permit. Pages Department of Important: If It any injury or o		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licent	1 1/10	22, Name and Address of Facility	BEPH O.	100000, 100 100000, 100000, 100000000000
STATE S	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Done use on each line.  Due to (or as a consequence).	o not enter the mode of dying, such as cardia  After a e off	c or respiratory arrest,	Approximate Interval Between Onset and Death URAYS URAYS
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consequence).  Due to (or as a consequence).			
P.O. Box 6	that the death certifica led by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1  Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
Vital Records,	The ate ha	e Completed	25. Was case referred to medical			24a. Was an autopsy performed? 1 Yes 2 DNNo	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
⋚		o B	examiner?	lospital: 1 ☐ Inpatient 2 X ER/0	Other	ath (Check only one) Home 5 Residence	6 MOther (Specify)
Division of	ing Viter une	Certification: T	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	. Time of linjury at Work?  M 1 Yes 2 No	28d. Describe how inju	
DIVI	tal or Att is after d al Direct ed in by	Certiff	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)
	the Hospital or Attand hin 24 hours after death the Funeral Director: A mpletely filled in by the fi	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exemi	sician: To the best of my knowled ner: On the basis of examination and manner stated.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	e, and due to the cause(s urred at the time, date and	) and manner as stated. d place, and due to the cause(s)
)	To the I	M	29b. Signature and title of certifier	com mo	29c. License number J+1128	200	te signed (Month, Day, Year) vary 30, 2004
	V		30. Name and a dress of person who vice to the vice of the state of th	100	V. Wolfe St B	altimore	City, MO 21287
DH	Sta Registr IMH 17 Rev 1/2	ar	FER 0 4 2004		frails)		

**ORIGINAL** 

	1	For State Registrar	State of Ma	ryland / Depa	artmer <i>rtificat</i>			and M		Reg. No.	2004	
Physician		1. Decedent's Name (First, Middle, L.	ast)						2. Date of Dea	Day	Year	3. Time of Deat
/Medica		Forrester			T	enti			FEBRUM		abol	
Examine	r '	4a. Fecility Name (If not institution, gr					Location o	f Death		4c. Cc	ounty of Deeth	l
		2922 Virginia 5. Social Security Number 6.		(In yrs. last birthday)	1 .	timo r 1 Year	ore	24 Hrs.	8. Date of Birt	th	9. Birth	place (State or For
Funeral Director		231-38-0528	XXM 2□F	71 Yrs.	Months	Days	Hours	Min.	(Month, Da 04 1	y, Year)	Cou	ntry) A
with the maryland or 28a-f show	<b>⊢</b>	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation							10d. Inside City Lin
tems 23s or 28s-f show at must be notified at	5	MD NA		Baltimo	re							1X Yes 2
be notified	2	10e. Street and Number			10f. Zi	p Code				10g. Citizer	n of What Cou	intry?
30 0	2	2922 Virginia	AVA			211	215			T	J.S.A.	
frems 23		11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Dece			gin? (Spe	cify Yes or No Rican, etc.)	- 14.	. Race - Amer Black, White	
당원 비		1 Never Married 2 X Married	1XIYes 2 □ N IYes, Give	lo	1 🗆 Yes		Specify:					lack
LENG!	d by	3 Widowed 4 Divorced	Year or Dates:				*1					
"natural", adical Exi	Сощрієє	15. Decedent's (Specify only highest g	Education rade completed)	16a. Dece (Give	dent's Usu kind of wa DO NOT i	ork done o	during most	t of workir	ng	16b. Kind	of Business/li	ndustry
than	E	Elementary/Secondary (0-12)  12th grade	College (1-4or 5	+)	Tail		,			Tail	lorino	Compan
and Mental Hygiene. s marked other than sumatic event, the	3	17. Father's Name (First, Middle, Las			Lali	.OL	18. Mothe	r's Name	(First, Middle,			Compan
sed o	0	Willie Valent	ino				Δrai	nint	ia Bei	nnett	-	
mari mati	-	19a. Informant's Name/Relationship		19b. Maili	ing Addres	s (Street			Route Number			p Code)
27 is		Elizabeth Vale	ntine-Wif	e 2922	Vir	gin	ia Av	ve,	Balti	more	Md 2	1215
if Health and Mental Hygiene. Item 27 is marked other than "nature other traumatic event, the Medical To Do Commission	-	20a. Method of Disposition		20b. Place of Disponentery, cre	osition (Na	me of			ate		ition - City or T	own, State
rtment of rtant: If it njury or o		1 Squal 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	Druid R				c 17 2	17/04	Dika	201111	A. Md
Department of Important: If it any injury or once.	1	21. Signature of Funeral Service Do			2 Name a	nd Addres	se of Facilit	v -	11/4-			<del>, , , , , , , , , , , , , , , , , , , </del>
Depa Impo any i		Robert B.	1 x man	4	arc:	Waba	H Wes	ave.	Balt	imore	Md.	21215
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	nplications that caused	the death. Do not en	ter the mo	de of dyin	g, such as	cardiac o	r respiratory a	rrest,	/	Approximate Interval Between
ysicia ysicia	ical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of): a consequence of):								
ph th	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic p					230	d. Date of delin	very Day Year
ned b a deta	<u>&gt;</u>	Part II. Other significent conditions	contributing to death b	ut not resulting in the	underlying	cause giv	en in Part I		23e. Did t	obacco use	contribute to	the cause of death
n sig	9	Chanic Obstra	chue ful	monary	Visi	au			1 🖎	Yes 2 🗆	No 3□Pro	bably 4 Unkr
s bac	piet								24a. Was	an :	24b. Were aut	opsy findings avai
ite ha	E								perfo	212 No	death? 1 ☐ Yes	2 12 No
certificate has rector, page 2	0	25. Was case referred to medical					26. Place	of Death	(Check only	one)		
this ce al direc	80	examiner? 1 ☐ Yes 2 ☑ 100	Hospital: 1  Inpatie	ent 2 ER/Outpatie	ent 3 🗆 🗅	Oth Oth	er: 4 🗌 Nu	rsing Hor	ne 5 Resi	dence 6 [	Other (Spec	ify)
After th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time ( y Year) Injury	of	28c. Injur Wor	y at k?	1	28d. Describe	how injury o	occurred	
within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be One Bleen of Ini	ury - At home, farm, si	M treet, facto		Yes 2 🗌		28f. Location (		Number or Ru	ral Route Number,
within 24 hours after death To the Funeral Director: completely filled in by the	Cert				Ale	d no obna sia	data an	d elaco d			, , , , , , , , , , , , , , , , , , ,	etated
24 ho 8 Fund etely f	Medicai	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Madical Ex	Physician: To the best aminer: On the basis o and manner sta	f examination and/or in	nvestigatio	a at the tir n, in my o	ne, date an pinion, dea	th occurr	ed at the time,	date and p	lace, and due	to the cause(s)
within 2 To the comple	₩	29b. Signature and title of certifier	1		25	9c. Licens	e number			29d. Date :	signed (Month	, Day, Year)
0,		> Allboak &	Glen			1+4	593	3/		Fo	brear	y 2, 20e
1		30. Name and address of person who Discount I	no completed cause of d	leath (Item 23a) (Type	Print)	- Ne	ephr	5 A	rene	Les 1	Baltu	y 2, 200 none, p
Stat		31. Date filed (Maria, Bay (Year)	004 32 Registr	ar's Signature	marke )	- 14-C	ynı	٧٠٠ ر	ve ju	- C.J. 1		

		-	For State Registrar	State of Maryland		artment of H			giene Reg. No. 20	004	03010
h	Dhuaiair		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ry 3, 20	Yeer	3. Time of Death
	Physicia /Medic	al -	Glenna Marie			45 Ch. Taur	-1tion of		4c. County		10:49am <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, give : 3801 Beamers Court	itreet and number)		4b. City, Town, or Sykes		Death		roll	
	Funeral		5. Social Security Number 6. Sex		ast birthday)			Hrs. 8. Date of Bin Min. (Month, Da	h		place (State or Foreign
	Director		301-201-349	<sup>1 M 2</sup> X <sup>F</sup> 70	Yrs.	Months Days	Hours	Nov 4,	1933	III	inois
	and W	-	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation				1	0d. Inside City Limits
	Maryli feho	for	MD Carroll	Sv	kesvi1	lle					1 ☐ Yes 2 🗑 No
	death with the Maryland ms 23s or 28s-f ehow	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a c	ralD	3801 Beamers Cour			2178			USA		- 1 - di
	er de	Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 € No	S.   13.	Was Decedent of H If Yes, specify Cuba	ispanic Origi in, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Had Bla	ce - Americ ick, White,	
30	urs aft	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specif	s. Wh	TE
Ş Ş	within 72 hours after death with the Marylan ene. Han "natural; or items 23s or 28s-f show To Medical Exacitizer must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occup	durina most (	of working	16b. Kind of B	usiness/In	dustry
2	within ine. than "	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired ecretary	1)		Dept.	of Ag	riculture
Maryland 21215-0036	Hygint, I		17. Father's Name (First, Middle, Last)				18. Mother	s Name (First, Middle			
au		To Be	Uknown (Ha	11)			Un	known			
ar	s 1 and 2 should I Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (T)					or Rural Route Numb			Code)
	1 and 1eaith om 27 ther tr		Mr. Thomas E. Wat					ykesville,	MD 2178		own, State
nor	0 = 1		1 Burial 2 Cremation 3 F  4 Donation 5 XOther (Specify)	temoval from State		osition (Name of matory or other place).dge Mausc		2/6/04	Elkridg		
altimore,	artmartm orts		21. Signature of Funeral Service Licens	Liteonium				Home & Cha			
ñ	Dep imp		Duan A.	Waiset				21784 (410			193)
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the death re cause on each line.	n. Do not en	iter the mode of dyin		ardiac or respiratory a			Approximate Interval Between Onset and Death
À	/Medical Examiner		resulting in death)	Due to (or as a consequence	uence of):						
Е	Z.d.iiiiioi	<u>a</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
760,	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):						
6876		dical		d							
	certification of the second	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Da	ate of delive	өгу
P.O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Med	in the past 12 menths?	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown		□Ectopic pregnancy □ Other (specify)	/		Me	onth	Day Year
о. О	at the	Phys	9 ☐ Unknown  Part II. Other significant conditions co		ulting in the	undorhing agusa gu	on in Part I	23a Did	obacco use con	stribute to t	he cause of death?
Vital Records,	Physician: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as it	by	Par II. Other significant conditions co	Tributing to death but not les	uiting iir the t	enderlying cause giv	GITHI PAICI.		Yes 2 No		pably 4 Dunknown
900	ne law re has bee ge 2 sho	Completed				· · · · · · · · · · · · · · · · · · ·		24a. Was	psy	prior to co	opsy findings available impletion of cause of
<u> </u>	The cate h	Con						perfo 1 ☐ Yes	irmed? 2.∏No	death?	2 □ No
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth		of Death (Check only			
	Phys or this oral di	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time	of 28c. Injur	y at	sing Home 5 Chesi 28d. Describe	how injury occur		y)
<u>o</u>	ath. r: Afte e fune	ation	1 VNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor M 1□	Yes 2 □ N	io			
Division of	after des Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - Al he building, etc. (Specif	ome, farm, s	treet, factory, office		28f. Location ( City or To		ber or Rura	al Route Number,
	To the Hospital or Attanding Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, dea	ith occurred at the tir nvestigation, in my o	me, date and opinion, death	place, and due to the h occurred at the time,	cause(s) and m date and place,	anner as s , and due t	stated. o the cause(s)
	To the To the To the Comple	Me	29b. Signature and title of certifier	0		29c. Licens			29d. Date signe	ad (Month,	Day, Year)
			> Xkillan	~. N.D.		DI	206	2	2/3	120	04
	6		30. Name and address of person who of		n 23a) (Type	. /	ELM	ERSBURG,	nd 21	784	P
3	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa		()			, , ,		
	Regist	rar	EED 0 / 200/	rencia	17	MARO Hal					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month. **Physician** ances /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Hours Yrs. Director orton, Usuel Residence of Decedent death with the Merylend 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryle Depertment of Heelih end Mentel Hygiene. Depertment of Heelih end Mentel Hygiene. Important: if item 27 is marked other than "natural; or items 23e or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at Marylana Edgewood 1 ☐ Yes 2/4 No Hartord Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21040 Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes, 20 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Merried 1□Yes 2/2No White Baltimore, Maryland 21215-0036 Specify: Specify: Be Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) Random House Elementary/Secondary (0-12) College (1-4or 5+) manager 12 NA 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary torest Rau 19a. Informant's Name/Relationship (Type, Print), (nephew) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Charwood Billingsley daewood 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State BelAiR 5 Other (Specify) Name and Address of Facility 21. Signature of Funeral Servica Licansee ( ans Funera 8800 Hartord Effective disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on eech line. Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) ALZHEIMERS PROBABIE DEHENTIA Examiner Due to (or as a consequence of Physician/Medical Examiner certificate has been signed by the ettending physicien and irector, page 2 should be deteched for use es the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of): Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown CORONART ARTERY Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? MALNUTRITION No No 1 🗆 Yes To the Hospital or Attending Physician: within 24 hours efter death.

To the Funerel Director: After this certifics completely filled in by the funerel director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Deeth 1 Natural 2 ☐ Accident 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 2 🗆 No 1 Tes 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner steted. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of cartifier 4000 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) FRANKLIN SQUARE DR. , BALTHORE, 105 31. Date filed (Month, Day, Year) 32. Registrer's Signeture Registrar

DHMH 16 Rev 6/95

1 - For Stete Registrar /Medical

The law requires that the death certificate be executed and burial-trar Box 68760. for use as the P.O. detached Records, ed bluods page 2 Division of Vital funeral director this After

CHARLES

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name\_(First, Middle, Last) :45 AM **Physician** EBRUARY 2004 HARLE 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner JALTIM ORE CHRIST TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 8 1)X M 2□ F 219.01.039 ARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No BALTIMORE BALTIMORE MARYLAND Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SA DEVONWOOD COURT 21237 9577 deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Items 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Maryland 21215-0036 WHITE þ 3 Widowed 4 ☐ Divorced "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Peges 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if I tem 27 is marked other than "ne eny injury or other traumatic aven" Elementary/Secondary (0-12) College (1-4or 5+) MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELEN OGAN UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HARLES L. WARNS, BALLYBAR RD, BALTIMORE, MD 21236 JR. JON 4621 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State GARDENS OF FAITH CEMERY FEB. 7, 2004 ROSEDALE, 4 □ Donation 5 □ Other (Specify) FUNERAL CHAPEL 22. Name and Address of Facility EVANS 21. Signature of Funeral Service Licenses 121 8800 HARFORD RD, PARKVILLE, MD 21234 23a. Parh. Enter the disease, or shock, or heart fallyre. List transdiate Cause (Final e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death VNG Monta ancer **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ robably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Cother (Specify) HOSPICE 1 ☐ Yes 2 → No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Exeminer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sign tu k and title of certifier 2004 EbRUARY 28303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fam J. Charles 20 Buttempre no 20204 6601 N. Charles ND 31. Date filed (Month, Day, Year) FEB 0 4 2004 \$2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yeer HITFIELD **Physician** 1320P 1DRey IVAR 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours 1 Ad-HARFORD KOAD BALTIMORE (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age 1□ M 2 🖫 **Funeral** 0 -40-5039 North Carolina Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a. State id 2 should be filed within 72 hours after death with the Marylar lift and Mental Hygiene. 27 is marked other then "neturel; or ftems 23a or 28e-f show treumatic event, the Medical Extrainer mail the notified at the unatic event, the Medical Extrainer mail the notified at 1 Xes 2 No 1 timore Directo 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 6055 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ∰ o If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ € 0 Baltimore, Maryland 21215-0036 Specify: lack Š 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hd 505 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other treumatic event 2008. Be Newborn Artis 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ralto-MD 21214 'enita 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ★Burial 2 □ Cremation 3 □ Removal from State DI 4 ☐ Donation 5 ☐ Other (Specify) uneral Sorvices 21. Signature of Funeral Service Licensee 0 Road Balto.MD 21212 Dre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LYDARS DOMONTIA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the all d be detached for Division of Vital Records, P.O. 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown BIZ DEFICIENCY 1 🗌 Yes WeIGHT LOSS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No ANEMIA 25. Was case referred to medical examiner? certificate Yes 26. Place of Death Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 2 No 1 Tyes 1 Inpatient 3□ DOA Certification; To this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. nerel Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide after Hospitel within 24 hours of To the Funerel 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) eq. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

BAYVIOW CIRCLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL A. AVKROW MD 5505 Hop.

31. Date filed (Month, Day, Year)

0 4 2004

			For State Registrar		State of Ma		partment of F Certificate of			jiene ea. No. 200	4 03016
			Decedent's Name (First,	Middle, Last	)				2. Date of Dea	th	3. Time of Death
	Physici	An .	Dwight	Ernes	<b>-</b>	Wilson,	Jr.		Month Januar	Day Yea y 28, 2004	1 21 3 1 21 14
	/Medic Examin		4a. Facility Name (If not ins			WIISON		r Location of Death		4c. County of De	
	Examin	61	119 Colony	Hill	Court		Ha1	ethorpe		Ba1t	imore
	Funeral		5. Social Security Number	6. Se	x 7. Age	(In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		hirthplace (State or Foreign Country)
	Director		165-22-5308	1 0	XM 2□F	75 Yrs	Months Days	Hours Min.	Jul. 16	1928	Pennsylvania
	p .		Usual Residence of Deced			10a Cibi Taura	- Location				10d. Inside City Limits
	show	<b></b>	10a. State 10b. C	County		10c. City, Town o	r Location				1 Yes 2 No
	Ba-f	Director	MD	Ba1	timore		Halethor	ре			
	or 2	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
	s 23e	Funeral	119 Colony	Hi11	Court 12. Was Decedent I	Turn in U.C.	13. Was Decedent of I	21227	anaiby Van as Na	United St	ates merican Indian,
	er de Item	nue	11. Marital Status 1 ☐ Never Married 2 ☑	7 Marriad	Armed Forces?		If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Black, W	
36	l'. or	by F	3 ☐ Widowed 4 ☐ Div	-	1 XIYes 2 ☐ N If Yes, Give Year or Dates: [	Inknown	1 ☐ Yes 2 💢 No	Specify:		Specify:	White
ŏ	2 hou			cedent's Ed	ucation	16a. De	ecedent's Usual Occup	oation	4-7-	16b. Kind of Busines	ss/Industry
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Exatrinar rulat be incliffed at	Completed	(Specify only Elementary/Secondary (		de completed) College (1-4or 5	· in	live kind of work done to DO NOT use retire	d) most or wor.	Kirig		
2	giene giene er tha	TO.	12				Laborer	1			Materials
g	al Hy I oth	Be (	17. Father's Name (First, A							Maiden Sumame)	
<u> a</u>	should band Ments marked	2	Dwight E. W:	ilson,	Sr.			Edith (	Gregg		
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ardment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or Items 23a or 28a-1 show injury or other traumatic event, the Madical Examination and be notified at a.		19a. Informant's Name/Re				lailing Address (Street				
	and ealth m 27 ner tr		Marjorie Wi		Wife		Colony Hi	.11 Court			
ore	Pages 1 nent of H int: if ited iry or oth	11.3	20a. Method of Disposition 1 ➡ Burial 2 ☐ Crem		Removal from State	cemetery,	isposition (Name of crematory or other pla W	ce)	Date	20c. Location - City	or lown, State
Ē	ment tant: jury o		° 4 □ Donation 5 □ O			Lakevic	Memorial F	ark 1-3.		Eldersbur	
Baltimore,	permit. Pages Department of Important: if i any injury or once.		21 Signature of Funeral S	ervice Liceni	No No	1/1/2				al Home, I	
	70 5 0		23a, Part 1. Enter the dise	MON	) reculu	J MULA	1328 Sulph				Approximate
			shock, or heart failure	ase, or comp e. List only o	one cause on each lin	ne death. Do not	t senter the mode of dyl	ng, such as cardiac	or respiratory an	est,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_	a Chion	ic where	nic myoci	induct d	bein		
	/Medical Examiner		resulting in dealin		Due to (or as	a consequence of)		1	4.	2.0.	5
		_	Sequentially list conditions if any, leading to immediate	3,	b. Due to (or as	a consequence of)	knowe cu	was row.	un ans		Jys.
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	ື ⊀	20010 (01 20						
	cate be executed oblysician and the burial-transit	хаг	that initiated events resulting in death) Last		C. Due to (or as	a consequence of)	:				
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687	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical			u						
Вох	eath certific attending p	N/	IF FEMALE: 23b. Was decedent pregn	ant	23c. If yes, outcome		-55			23d. Date of d	delivery
m	death e atte d for	cla	in the past 12 months 1 ☐ Yes 2 ☐ No		4 Pregnant at	2 ☐Fetal death time of death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у		Month	Day Year
P.O.		hys	9 🗆 Unknown		9□ Unknown						
	res tha igned be del	by P	Part II. Other significant c	conditions of	ontributing to death b	ut not resulting in th	ne undertying cause gr	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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æ	0 - 0	mo							perfor	med? death	
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to rexaminer?	medical				26. Place of Dea	th (Check only or	ne)	
<b>2</b>	Physician: this certificanal director,	P	Yes 2 No	1		ent 2 EP/Outp	atient 3 DOA	her: 4 🗆 Nursing H	lome 5 X Resid	ence 6 Other (S	pecify)
u u	ding Pl n. After ti funera		27. Manner of Death	Pending	28a. Date of Inju (Month, Da	ry 28b. Tin y Ye <i>ar)</i> Inju	iry Wo	rk?	28d. Describe h	ow injury occurred	
Sio	Attanding or death. ector: Atter by the fune	catl	2 Accident	investigation Could not be				]Yes 2 □No			
Division of Vital Records,	or Attandater death Director: In by the	Certification;	4 Homicide	determined	200. Place 01 IIII	ury - At home, farm c. <i>(Specify)</i>	, street, factory, office		City or Tow		Rural Route Number,
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	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical				f examination and/o	death occurred at the toor investigation, in my				
	within 2 To the comple	Me	29b. Signature and title of	certifier	A.	160.	29c. Licen	se number		29d. Date signed (Mo	onth, Day, Year)
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,	1 Wh		30. Name and address of	nereon who	completed cause of a	leath (Item 23a) (To				Vanuary	
	The state of the s		J. CRUSSAN			D 211	2 DUNDA	LIC AVE	BAL	TO. MD	21222
	St	ate				ar's Signature					
	Regist		31. Date filed (Month, Day	84 -	2004	Repensa	6 ,	R			
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			1 - For State Registrar	State of M	laryland	-	irtment of tificate of				iene2 () og. No.	04	030	)15
			1. Decedent's Name (First, Middle, Last	)					- 1	2. Date of Deat Month	h Day	Year	3. Time of	Death
	Physicia /Medic		HOWARD	F	RANCIS		Ţ	VEAVER		JÄNUARY		004	9:30	A M
	Examin		4a. Facility Name (If not institution, give	street and number	)		4b. City, Town,	or Location	of Death		4c. Count	y of Death		
			110 OTIS DRIVE					EVERN					RUNDEL	
	Funeral		5. Social Security Number 6. Se	x 7.A XM 2□F	ge (In yrs. las	it birthday) Yrs.	If Under 1 Year Months Day		Min.	8. Date of Birth (Month, Day,	Year)		place (State ontry)	or Foreign
	Director		219-05-9411 Usual Residence of Decedent		83	Trs.			0	9/09/19	20	MAR	RYLAND	
	and and		10a. State 10b. County		10c. City,	Town or Lo	cation					· ]	10d. Inside C	ity Limits
	Mary f eh	ţō	MD ANNE ARU	INDEL		GLE	N BURNI	Ξ					1 ☐ Yes	2 🕅 <b>X</b> O
	the	Director	10e. Street and Number				10f. Zip Code			1	Og. Citizen of	What Cou	ntry?	
	ours after death with the Marylan rai', or items 23a or 28a-f ehow Exercities most be notified at	0	7466 FURNACE BRAN	ICH ROAD	#424		21060	)			U.S	.A.		
	ter death	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S.	13. \	Vas Decedent of Yes, specify Cu	Hispanic Or	rigin? (Spec	ify Yes or No-		ce - Ameri	can Indian,	
9	after or Ite	F.	1 ☐ Never Married 2XXMarried	1 X X es 2 ☐ If Yes, Give			Tes, specify Co			ican, etc.)		tek, white, ty: WHI		
8	72 hours after death with the Maryland Insturat', or Items 23a or 28a-f ehow disal Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	WWII		THE TAKE		•					
5-	be filed within 72 hours hal Hygiene. of other then "natural", event, the Medical Exp	Completed	15. Decedent's Edi (Specify only highest grad	ication le co <i>mpleted)</i>		(Give	lent's Usual Occ kind of work don	e during mos	st of working		16b. Kind of B	Business/In	ndustry	
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7	e filed within at Hygiene. other then "		12 17. Father's Name (First, Middle, Last)				ELECIKI		er's Name /	(First, Middle, N			GUAND	
Maryland 21215-0036	ntal l	Be c	GEORGE WEAVE	}					HARLO			,		
2	2 should be and Mental Is marked o	2	19a. Informant's Name/Relationship (T		1	19b. Mailir	g Address (Stre				City or Town	. State. Zic	Code) 2 1 (	260
Ma	and 2 sealth arm 27 is			- WIFE			FURNAC							
ē,	1 al Hea Hea tha		20a. Method of Disposition		COT	ce of Dispo	sition (Name of natory or other p	(ace)	Da	ite :	20c. Location	- City or T	own, State	
Ê	0 0 = 5		tXXBurial 2 ☐ Cremation 3 ☐ i  4 ☐ Donation 5 ☐ Other (Specify)				N MEMOR		3 FEB	2004	GLEN B	URNIE	E, MD	
Baltimore,	그 문문을 .		21. Signature (CEIneral Genues Ucans	809		22	. Name and Add	ress of Facil	ity FI	NK FUNE	RAL HO	ME, F	PA	
ä	Depermine only is		KELLY GREGORY	FINK #M	01148	42	6 CRAIN	HWY.,	S, G	LEN BUR	NIE, M	D 210	061	
	Physician /Medical Examiner	e	23a. Part1. Enter the disease, or camb shock, or neart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	ne cause on each  a. Due to or a	s a conseque	nce of):	reumon	σ,					Approximal Interval Bet Onset and	reewi
68760,	ficate be executed g physician and is the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	c Due to (or a	s a conseque	nce of):								
O. Box	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant i 9 ☐ Unknown	2 Fetal d	eath 3	Ectopic pregnar Other (specify)	су				ate of delivonth	-	Year
٦,	ires that signed b	by Pi	Part II. Other significant conditions co	ntributing to death	but not resulti	ing in the u	nderlying cause	iven in Part	l.	23e. Did tob	acco use con	tribute to t	he cause of	death?
rg	w require been sig should b	pa P	Chronic Olytra	ctive P	ulmen	ory	arter	0		1 ☐ Ye	s 2 🗆 No	3 Prol	bably 4 🗆	Unknown
S	aw requis been 2 should	Completed		/		(/				24a. Was ar	24b.	Were auto	opsy findings empletion of c	available
Ä	The lav	E								perform	ned?	death?		2000 01
ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Plac	e of Death	(Check only on	9)			
of Vital Records,	Attending Physician: r death. ector: After this certific by the funeral director.	2	1 □ Yes 2 XXVo	Hospital: 1 🗆 Inpat		NOutpatien	1 30 DON		ursing Hom	e 5 🗌 Reside	nce MXO	ier Specia	Resid	dence
n	ding P h. After ti funera		27. Manner of Death  XX Natural 5 ☐ Pending	28a. Date of In (Month, D	ay Year) 2	8b. Time of Injury	W			3d. Describe ho	w injury occur	rred		
sio	death. ctor: A / the fu	catl	2 Accident investigation 3 Suicide 6 Could not be					Yes 2						
Division	or At fiter d Direct in by	Certification:	4 Homicide determined	28e. Place of In	njury - At hom atc. (Specify)	e, farm, str	eet, factory, offic	Э	28	3f. Location (St. City or Town		ber or Rura	al Route Nun	nber,
	pital ours a eral [		29a. Certifier W. Certifying Phy	reinian: To the bee	t of my knowl	adaa daatt	a courred at the	timo dato a	nd plane an	ad due to the se	1100(n) and m		stated	
>	24 ho Fun etely	edical	(Check only one)		of examinatio									s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and tit				29c. Lice	nse number		25	d. Date signe	ed (Month,	Day, Year)	
	F 5 F Ö		Della	MI			20	958	•		2/2/1	54		
	180		30. Name and address of person who o			3a) (Type.	Print)	100	,		1,7	1		
	51		Dafoit Sunt	Gull	1413	An	rapelin	Ropul	#/	06 0	clento	I it	102111	3
¥5.	Sta	ate rar	31. Date tileb (Menth) Day. Year) 4	32. Regis	trar's Signatu	3346	4							

			For State Registrar	State of Ma	ryland		artment of tificate of		nd Me		giene 0	04	03016
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	e	War	d				Date of Dea Month	Day	Year _004	3. Time of Death
>	Examin		4a. Fecility Name (If not institution, give s  Shady Grove A  5. Social Security Number 6. Sex	dventist		tal	4b. City, Town	or Location of Rockvi	11e	. Date of Birt	h	lonte	SOME TY  pplace (State or Foreign unity)
20	Funeral Director			M 2 <b>∑</b> F	53	Yrs.	Months Day	s Hours	Min.	(Month, Da ebruary	y, Year) 19, 1950	Cou	Maryland
	aryland •how	5	10a. State 10b. County		10c. City, T	own or Lo		_					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-f	Director	Maryland   Montgo	omery			10f. Zip Code	Germant	own		10g. Citizen of	What Cou	untry?
	s 23a		19268 Circle (	Gate Drive			Was Decedent o	2087		fy Yes or No			States
920	72 hours after death with the Maryland Insturet, or Items 23e or 28e-f show digal Establicational be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ☑ N  If Yes, Give  Year or Dates:			Was Decedent of Yes, specify Cu 1 ☐ Yes 2 💢 N		Puerto Ric	can, etc.)	Special Special	.ck, White fy:	
5-0		eted	15. Decedent's Educ (Specify only highest grade	ation completed)	1	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most	of working		16b. Kind of B	lusiness/li	ndustry
121215-0036	e filed within 72 he il Hygiene. other than "naturent, II.a Medica.	Completed	Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last)	College (1-4or 5	+)	me.		Bus Dr		First Middle	Montgor Public		County ools
lanc	be d a	To Be		nard Noves	3			lo. Monto			Mary V		
Maryland	an and		19a. Informant's Name/Relationship (Type Michael Irving War	oe, Print)		19b. Mailir 19268 Germa	ng Address (Stre Circle ntown,	Gate D	ror Rural F Orive	#202	er, City or Town	, State, Zi	ip Code)
Baltimore,	Pages 1 and 2 ent of Health at: If item 27 i y or other tre		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		20b. Plac	e of Dispo etery, crei Lawn	sition (Name of matory or other p	lace)	Febru 6, 20	0	20c. Location	,	rown, State Le, Maryland
Baltii	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Fundral Service License	cho A	M0033	22		tress of Facility	Rohe	rt A	Pumphre	37 F11	neral Home
	Physician		23a. Part1. Enter the disease, or compling shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused e cause on each tin	the death.	Do not ent	er the mode of d	ying, such as o	cardiac or r	espiratory ai	rrest,		Approximate Interval Between Onset and Death
6.	/Medical Examiner		resulting in death)	Due to (or as a									3 MONTH S
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a									
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 profiths? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3[	⊒Ectopic pregnai ∃ Other (specify)					ate of deli-	very Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death bu	ıt not resultii	ng in the u	nderlying cause	given in Part I.				-	the cause of death?
Vital Records,	The law requisate has been page 2 should	Completed							_ '	24a. Was autop perfo 1 Yes		Were aut prior to c death? 1 \( \text{Yes}	topsy findings available completion of cause of
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospitat:				1ther		Check only o		/	
of	ng Ph áter th ineral	tion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	y 28	VOutpatier Bb. Time o Injury	f 28c. ir	4 🗆 Nui	28		dence 6 Oth		<u> </u>
Division	al or Attendi s after death. Il Director: A od in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of trip building, etc	iry - At home . (Specify)	e, farm, st	reet, factory, offic	се	28	f. Location ( City or Tox		ber or Ru	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination		examination								
	To the within To the comp	Me	29b. Signature and title of certifier			4	29c. Lice	ense number			29d. Date signi	ed (Month	i, Day, Year)
•	m		PANNUT AT	T P. KUI	20010	32) Time	10 04	0107		ŀ	-EKRUAG	44	,2004.
		ate	30. Name and address of person who co	M	ar's Signatur	3a) (1ypa,	29c. Lice NO 14 Print)	HER H	1208,	Roc	KUME	M	20802
	Regist			0 4 2004	Line of the same	Poez a	K &	24.80 5					

	_	1 - Stete Amend Item 5 Registrar	per informar	it G849 1	lificate of				0301
		1. Decedent's Name (First, Middle, La	ist)			1	<ol><li>Date of Death Month</li></ol>	Day Yea	3. Time of Death
Physicia /Medic	_	Helen Evelyn Weed	la			1	February		5:40 A N
Examin	_	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death		4c. County of De	ath
		8804 Montgomery A	venue		Chevy Ch			Montgom	2
neral ector		71611 101 1176 /	1 DM 2187 E	yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day, June 23,	9. 8 1916 Co	irthplace (State or Foreig Country) nnecticut
		Usual Residence of Decedent  10a. State 10b. County	110	c. City, Town or Lo	anting				10d. Inside City Limits
find at	tor	Maryland Montgome		Chevy Cha					1⊠Yes 2□No
or other traumatic event, the Mudical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code 20815-4	706	10	g. Citizen of What G	
1	era	8804 Montgomery A	12. Was Decedent Ever	in U.S. 13			ifv Yes or No-		nerican Indian,
	by Funeral	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2⁄2 No	ispanic Origin? (Spec in, Mexican, Puerto R Specify:	ican, etc.)	Specify: Wh	
	ed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Busines	
Trans.	Completed	(Specify only highest g		(Give	kind of work done of DO NOT use retired	during most of working f)	, l	Veterans	
	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Admi	nistrator	r	i	dministra	ation
		17. Father's Name (First, Middle, Las	t)			-18. Mother's Name	First, Middle, M	laiden Sumame)	
	o Be	James Maccioca				Sofia Gre	goria		
Tage.	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rural	Route Number,	City or Town, State	Zip Code)
		Rosanne Shepler/				reet, S.W.			
ı y		20a. Method of Disposition		Oh Place of Disno	estion (Name of	Da	te 2	Oc. Location - City	
ODCS.		1 X Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Special Control of Funeral SerVice Lick	ify)	Cemet	2. Name and Addres	ss of FacilityRobe:	At A. Pu	mphrey F	Virginia uneral Home ensin Avenu
		23 Part I anter the disease, or conshipting Course (Carl	nplications that sused the y one cause on each line.	death. Do not en	ter the mode of dyin	g, such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
ian		Immediate Cause (Final disease or condition resulting in death)	<sub>a.</sub> Pneumonia	a					ļ <u>.</u>
cal ner		resulting in dealin)	Due to (or as a co		. 1				
	_	Sequentially list conditions,	Congestiv		myopatny				
-	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence or):					
the burial-transit	Ilcal Examiner	that initiated events resulting in death) Last	Due to (or as a co	ensequence of):					
as	Mec	IF FEMALE:							
shed for use as the t	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of d Month	elivery Day Year
should be detached f	by Ph	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	inderlying cause giv	eņ in Part I.	23e. Did toba	acco use contribute	to the cause of death?
							1 ☐ Yes	s 2፟፟⊠No 3∏	Probably 4 □Unknov
Shot	lete						24a. Was an	24b Were	autopsy findings availat
page 2	Completed						autopsy perform 1 Yes 2	prior to led? death	completion of cause of
director, pag	Be	25. Was case referred to medical examiner?	11a itali		(8)	26. Place of Death			
al dire	၉	1xx Yes 2 □ No		2 ER/Outpatie		er: 4 Nursing Hom			pecify)
nera	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injun Wor	y at 28 k?	ld. Describe how	w injury occurred	
on for	Certification:	2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine	be age Blace of Injury	At home, farm, st		Yes 2 □ No	of. Location (Str. City or Town,		Ru <i>ral Route Number,</i>
Ď	edical Ce		Physician: To the best of mainer: On the basis of examiner and manner stated	amination and/or in					
etely fille		29b. Signature and title of certifier			29c. Licens	e number	29	ld. Date signed (Mo.	nth, Day, Year)
smpretery title	Me			1.0				•	
completely fille	Me	1 0	1 much	MID	D2766	50	F e	ebruarv 2	, 2004
completely fille	Me	> Alparaly		M.D.		50	Fe	ebruary 2	, 2004
completely filled in by the funer	Me	30. Name and address of person wh		n (Item 23a) (Type,	Print)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state State PegistraphenD ITEM #10c PER FH G828 2/04/04 Gentificate of Death Reg. No. 4 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 24, 2004 **Physician** 1:05 pM Daisie May Waite /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 10, 9. Birthplace (State or Foreign Country)
Vermont Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**ॉ**F Yrs. 009-38-6049 94 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show the Medical Exertiner Trust be notified at 1 ☐ Yes 2 ☐ No Director Harford P.O. Box 621 ABERDEEN Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21001 U.S.A. P.O. Box 621 or Items 23a Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☑ Widowed 4 □ Divorced natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) teacher school permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any injury or other traumatic event, I'm ODG. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Amy Belle Manning Arthur James Swinyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 621 Aberdeen, Maryland 21001 Juna Swinyer- sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Balt/Wash. Crematory | 2/2/2004 Laurel, Maryland 22. Name and Address of Facility Miller-Dippel Funeral Home 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, Maryland 21206 Ssice 23a. Rart1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner attending physician and for use as the burial-transit NOS that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 W No 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an has 2010 1 ☐ Yes Division of Vital : After this certifica e funeral director, r 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Marner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: or Attending □Natural 5 Pending 2 🗆 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name an address of person who completed cause of de

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day

Year)

		1	_ State	State of Maryland / Depa	artment of Health and M tificate of Death		CIUCU PUUL
			Registrar  1. Decedent's Name (First, Middle, Last)	Oei	incate of Death	Reg. N 2. Date of Death	3, Time of Death
	Physicia /Medic	an*	Anthony Jol	nn Zakoscielny	, Jr.		Pay Year 2./12 PM
¥	Examin		4a. Fecility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death	4	c. County of Death
			432 Imla Street		Baltimore		n/a
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) M 2□ F 84 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Jan 21.	9. Birthplece (State or Foreign Maryland
7			Usual Residence of Decedent				
Z	how	.	10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits
Ma	- I	Director	Md. n/a	Ва	altimore		1 X Yes 2 No
h the	or 28	ire	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
3	2		535 South Ros	e Street	21224		USA
9	£ 5	Funerai	11. Marital Status	2. Was Decedent Ever in U.S. 13. \Amped Forces?	Was Decedent of Hispanic Origin? (Sport Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
o de	or it		1 Never Married 2 Married	1 14 as 2 1 No	1 ☐ Yes 2 ☒ No Specify:		Specify: White
3-0030	in rational and bear min to may an in an article and an inatural, or items 23a or 28a-1 show Madical Examiner must be notified at	d by	3 Widowed 4 Ovorced	Year or Dates:		1.0	
ה ה	natr.	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of work: DO NOT use retired)	ing 16b.	Kind of Business/Industry
Maryland AIAID-0030	. Pa	m m	Elementary/Secondary (0-12)	College (1-4or 5+)	tenance	Go	vernment
<b>V</b> 200	I Hygie other t		17. Father's Name (First, Middle, Last)			(First, Middle, Maide	
P P	E d is	Be	Anthony John Z	akoscielny, Sr	Louise	Slaga	,
aryla should	Merke	ဥ	19a. Informant's Name/Relationship (Typ		ng Address (Street and Number or Run		v or Town State Zin Code)
Nai	h and 7 is m Iraum		Estelle Helinsk				, Md 21224
	item 2		20a. Method of Disposition	20b. Place of Dispo			Location - City or Town, State
			1 Burial 2 Cremation 3 □Re	emoval from State cemetery, crer	matory or other place)		
	permit. rag Department Important: I any injury o once.		* 4 ☐ Donation 5 ☐ Other (Specify)	St. Star			ltimore, Md.
Saitimore,	opar opar npor ny in		21. Signature of Funeral Service License				Funeral Home, PA
	20 E e Q		Cuque y		201 Dundalk Ave		
			23a. Part1. Enter the disease, or/complice shock, or heart failure. List only on	ations that caused the death. Do not ent e cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition	MYOCARDIAL	INFARCT10	$\sim$	
	/Medical		resulting in death)	Due to (or as a consequence of):			
	Examiner		Sequentially list conditions.		ARTERY DI	SEASE	
T	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
of	acute trans	Examin	that initiated events c. resulting in death) Last	Due to fer as a consequence of:			
Š,	rate be executed bhysician and the burial-transit	Û	(Osailing III doddi) Last	Due to (or as a consequence of):			
8760,	sate can	dical	d	The state of the s			
٥	seath certifica attending ph for use as t		IF FEMALE:	On Marian automo of property		-13	
Rox	ttend or us	Physician/Me	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delivery  Month Day Year
7	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5 [ 9☐ Unknown	Other (specify)		
J.	that the de ned by the a detached f	F.		tributing to death but not resulting in the u	indertying cause given in Part I	23e Did tobacc	to use contribute to the cause of death?
Ś	8 25 9	<u>م</u>	Part II. Other significant conditions con	Tibuting to doubt but not resembly in the o	madifying daddo giron in i arri.		2 No 3 Probably 4 Unknown
0	w require been signal should b	Completed					
ec	law lasb	npie				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
# P	The page	Co				1 ☐ Yes 2 ☐	
/ita	sician: The law s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	a acitat.		h (Check only one)	Sigter's
	Physic this c	၉	Tes ZENO	ospital: 1 Inpatient 2 ER/Outpatier		me 5 Residence	
ם נו	ding P	ü	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury 28b. Time of (Month, Day Year) 1njury	Work?	28d. Describe how in	Jury occurred
Division of Vital Records,	Attending Physician: It death. ector: After this certifice by the funeral director; s	Certification;	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	29f Loanting (Street	and Number or Russi Route Number
Σ	or Attendate death	E	4 Homicide determined	28e. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office	City or Town, St.	and Number or Rural Route Number, ate)
	urs a			I Table 1 of the second	<u> </u>	and due to the	/a) and managed
	To the Hospital or Atlending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Examin	sician: To the best of my knowledge, deather: On the basis of examination and/or in	in occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	the hin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29d. S	Date signed (Month, Day, Year)
i	2 × 0 0	1	250. Signature and title of Certifier	1/	D44315		bruary 2, 2004
7	(,		· · ·	~ // L			
	φ		1	mpleted cause of death (Item 23a) (Type,	Print) OSTER AVENUE	RAIT	THORE MD 21224
			VINCEN TO GRI 31. Date filed (Month, Day, Year)	32. Registrar's Signature	USIOR INDIVIDE	- ロッレー	"WILD I'V ULLY
	St	ate	FFR 0 4 2004	32. Hegistran's Signatur			

# Copies Are Legible.

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DAP	For Unpend	State of Maryland / Department of Health and Mo

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		1. Decedent's Name (			-						2. Date of D Month			ear	3. Time of Death
hysic? Medi/		Gregor	y J	ames	Zorn		,			E	EBRUA		2004		6:26 a
Examii		4a. Facility Name (If n SUBURBAN	_		er)		4b. City, 1 BETH		Location of [	Death			County of DNTGOM		
uneral		Social Security Num			Age (In yrs.	last birthday)	If Under		If Under 24		8. Date of B	irth			ce (State or Foreig
rector		217-56-8167		1 M 2□F	5	2 Yrs.	Months	Days	Hours	Min.	Month, D	1951	1	Mary la	and
> -		Usual Residence of D	ecedent 10b. County		10c Cit	ty, Town or Lo	ocation							104	. Inside City Limits
sho and a	5	MD MD	n/a			altimore								100	1 ☑ Yes 2 ☐ No
28a-i	Director	10e. Street and Numb				a rombi c	10f. Zip	Code				10g. Cit	izen of Wha	t Country	?
3a or	0	3803 Bayo	onne Avenu	ıe				2120	6				USA		
ama 2	Funeral	11. Marital Status		12. Was Decede Armed Force	nt Ever in U	.S. 13.	Was Decede	ent of His		? (Spec	cify Yes or N	0-	14. Race - A	American White, etc	
item 27 is marked other than "natural", or itema 23s or 28s-1 show other traumatic event. Its Modical Examinations to notified at	by Fu	1 Never Married		1 Tes 2	No	ĺ	1 ☐ Yes 2		Specify:				Specify:	White	
tural Ex		3 Widowed 4	5. Decedent's E	Year or Date	s:	16a Dece	dent's Usual	I Occupa	tion			16b K	ind of Busine	ass/Indus	etry
an n	Completed	(Specify	only highest gr	ade completed)  College (1-4c	25 E . \	(Give	kind of work DO NOT use	k done d	urina most oi	workin	g	100.10	and or bushin	0334111341	3.0 y
at a	E	12	Jary (0-12)	2	JI 5+)	Ca	arpente	r				ISE	C Const	tuctio	on_Services
d oth	Be (	17. Father's Name (Fi									(First, Middle	e, Maiden	Sumame)		
arke atic	2	Edward		orn					Berna				Borowsk		
7 Is m traum		19a. Informant's Nam Renee E. Zor		(Type, Print)					nd Number o nue, Ba		Route Numb	ber, City o 2120		te, Zip Co	ode)
em 2 sther		20a. Method of Dispos			20b. F	Place of Dispo	osition (Nam	ne of			ate		ocation - City	y or Town	, State
Important: If item 27 Is any injury or other tra QDCB.		1 □ Burial 2 🖔 1 □ Donation 5		Removal from Sta	te Hil	cemetery, crei 1top Ser	matory or oti vice Co	ther place OMPOM	ation 2	/9/04	1		wson, M		
injur		21. Signature of Fune			n G. Dai	u 2	2. Name and	d Addres	s of Facility	Leor	nard J.				1 Home
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edical miner	nlner	shock, or heart to Immediate Cause (Fi disease or condition resulting in death)  Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in Cause	failure. List only inal litions, rediate	a. Ather Due to (or	oscle	rotic (	ter the mode	e of dying	, such as ca	rdiac or	respiratory a		21214	In	iterval Between
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State Registrar

31. Date filed (Month, Day, Year) FEB 0 4 ZUU4

111 Penn Street, Baltimore, Maryland 21201

	1 - For State Registrar			iviai yiai			of Death	nd Mental Hy	Reg. No.	0302
ician		Name (First, Middle,						2. Date of De		3. Time of Death
dical	308	eph Franc						Januar	y $28^{2}$ , $200$	4 5:12 P M
niner			give street and num			4b. City, Tov	m, or Location of	Death	4c. County of	Death
			Vharf Road			Avenue			St. M	ary's
al or	5. Social Secu 214-28		6. Sex 7 1⊠M 2□F	. Age (In yrs. 72	last birthday) Yrs.	If Under 1 Y Months Da	ear If Under 2	Min. 8. Date of Birt Month, Da January 1	h y, Year) 12, 1932 Ma	Birthplace (State or Foreig Country) aryland
	10a. State	10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
ţ	Maryland	St. Ma	ary's		Aven	ue				1 ☐ Yes 2XXNo
Director	10e. Street and					10f. Zip Coo	de		10g. Citizen of Wha	at Country?
	38963	Cobrums V	Wharf Road				20609		US.	Α
Funeral	11. Marital Sta	tus	12. Was Deced	ent Ever in U	.S. 13. V	Vas Decedent		n? (Specify Yes or No- Puerto Rican, etc.)	14. Race -	American Indian,
2	3 ☐ Widow	Married 2∛∭Marrie ed 4⊡Divorced		□ No		Tes, specify (		Pueno Alcan, etc.)	1	White, etc. White
Completed		15. Decedent's Specify only highest	Education		16a. Deced	lent's Usual Oc	ccupation one during most o stired)	dadela a	16b. Kind of Busin	ess/Industry
gu	Elementary/	Secondary (0-12)	College (1-4	lor 5+)	life. L	OO NOT use re	ntired)	or working	_	
O		10			Eng	ineer			Transpo	rtation
B	17. Father's Na	ıme (First, Middle, Li	•		_			s Name (First, Middle,		
P	!	Fra	incis Edga	r Abel	.1		Marg	garet Mary	Graves	
	19a. Informan	's Name/Relationshi	p (Type, Print)					or Rural Route Numbe		
		ances Abell/	/Wife					, Avenue, Mar	yland 20609	
	20a. Method of		B □Removal from St		Place of Disposemetery, crem	sition (Name of natory or other		Date Druary 2,	20c. Location - City	y or Town, State
		ion 5 Other (Spe			rles Mem	orial Ga			Leonardtown	, Maryland
	21. Signature	of Funeral Service Li	censee	-	22. M	Name and Ad	Idress of Facility			
	Mu	Leael Ke	Harde	ner	P	.O. Box	y-Gardiner 270 Leona	Funeral Homerdtown, MD 2	P.A.	
	23a. Parth. Er shock, or Immediate Ca disease or cor resulting in de	use (Final	_ a	m iine.	TATIC		dying, such as ca	rdiac or respiratory arr	rest,	Approximate Interval Between Onset and Death
ē	Sequentially lis	it conditions,	b	as a consequ						
Examiner	Sequentially list if any, leading cause. Enter to Cause (Diseas that initiated eversulting in dea	Indertying e or injury ents tth) Last	c Due to (or	as a consequ	uence of):					
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by	Part II. Other si		s contributing to deat		ulting in the un	derlying cause	given in Part I.	23e. Did tot		e to the cause of death?  Probably 4 Unknown
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e C		oforced to modical						1 ☐ Yes 2	2 1 □ Y	
o Be	examiner?	eferred to medical	Hospital:				24	Death (Check only on	-4	
<b>—</b>	1 Yes		1 lnp		ER/Outpatient	3 DOA		ng Home 5 Reside		Specify)
_	1 Natural 2 Accide	5 ☐ Pending nt investigat	ion	Day Year)	28b. Time of Injury		Yes 2 No	28d. Describe ho	w injury occurred	
catlor	4 Homici		289. Place of	Injury - At ho etc. (Specify	me, farm, stre	et, factory, offic	CO CO	28f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,
Certification:					wledge, death	occurred at the	time, date and p	lace, and due to the ca	use(s) and manner	' as stated
edical	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical Ex	Physician: To the be aminer: On the basis and manner	s of examinat	ion and/or inve	stigation, in m	y opinion, death o	occurred at the time, da	ate and place, and o	due to the cause(s)
	29a. Certifier (Check only one)	and title of certifier	aminer: On the basis	stated.	ion and/or inve	stigation, in m	y opinion, death o		ate and place, and c	due to the cause(s)
edical	29a. Certifier (Check only one)	and title of certifier	aminer: On the basis	stated.	ion and/or inve	29c. Lice		29	ate and place, and c	onth, Day, Year)
edical	29a. Certifier (Check only one) 29b. Signature	and title of certifier	aminer: On the basis	s of examinat stated.	23a) (Type, P	29c. Lice D 5	onse number O686	29	ate and place, and conditions of the signed (Months)	onth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrer Amend Item#24aperVERBALG8282/25/04Contificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:35 A M 4a. Facility Name (If not institution, give street 04 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner MD 5. Social Security Number 6. Sex Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day) 1<u>959</u> **Funeral** Hours Min. 1 M 2 XF Yrs. 14 MD Director 219-74-3340 44 Sept Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No Director MD Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21158 USA 397 Doral Court Івета 23а permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itema 23s any injury or other traumatic event Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Leister Imogene Roser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Andrews/husband 397 Doral Court Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 □ Donation 5 □ Other (Specify) Pipe Creek Cemetery 1/23/2004 Linwood, MD 21. Signature of Funeral Service Licensee Pritts Funerally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a la consequence Examiner wk a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 XYes 2 □ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this anner of Death filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Alter 5 Pending Natural death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinary On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar nd addres

31. Date filed (Month, Day, Year)

Raochoy

DHMH 17 Rev 1/2001

ORIGINAL

person who completed cause of death (Item 23a) (Type, Print) 22

32. Registrar's Signature

6637

S#reet,

Gregne

MD

Bal/timore',

21201

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:13 P **Physician** 2004 01 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HARFORD GARDENS Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Feb 11, 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ₩ F 85 Director 229-74-5664 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits rai', or items 23a or 28a-f ahow Examiner must be notified at Owings Mills 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 Rosewood Lane USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced \*natural', 7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental Calvin Mills Albers Hazel Virginia Fowble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any injury or other traugonce. Charles O. Fisher, attorney 179 E. Main Street, Westminster, MD 21157 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grave Run Cemetery 01/16/2004 Hampstead, MD 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ungshwe /Medical Due to (or as a consequence of): **Examiner** Demen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Exam Due to (or as a consequence of) P.O. Box 68760, physician Droca Physician/Medical use as the attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy performed certificate 1 Yes 2 No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Matural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) lilled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Fune completely fi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WI MD D31464 1114104 N 21201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smite 42 30cf N. ENTAN m1)2116 StOA113 A. HASHOOI 821 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Allem B. Sporte

State of Maryland / Department of Health and Mental Hygiene? 03024 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** JUNE HOLLAND **ANDREWS** 0428 04 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner NICOMICS PONINSULA KEGIONA SALISBUR 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) June 19,1923 Birthplece (State or Foreign Country) **Funeral** Days 1 □ M 2 X F 218-16-7480 80 Yrs. Director Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10h. County 10d. Inside City Limits or 28a-1 show injury or other traumatic event, the Medical Examinar must be rediffed at 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3003 Merritt Mill Rd. 21804 USA "natural", or items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🏖 No Specify: ģ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be fited within 72 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental William T. Holland Sr. Jane Kirwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau Charles S. Andrews/husband 3003 Merritt Mill Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial Park 1/19/04 Salisbury, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association and of. Crompoor 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LYMPHOMA YEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 1 Yes Division of Vital 2 - NO Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ို 1 Inpatient 2 ER/Outpatient 3□ DOA his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D29168 Robert alle , M.O. 1/15/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAUJBURY AL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	Physici	an	Decedent's Name (First, Middle		42424					Date of De. Month	Day	Year	3. Time of Death
	/Medic	cal	DAVID C		APARA	•	4b. City, Town	or Location	of Death	anua	7	anty of Death	/ · / > / M
	Examin	ier	Franklin So	^	Hosp	1+01	0 /	200	12		Bo	1+/	mare
	Funeral		5. Social Security Number	6. Sex 1 □ XM 2 □ F	7. Age (In yrs.	last birthday)	If Under 1 Yes		24 Hrs. 8	Date of Birt (Month, Da	h v. Year)	9. Birth	place (State or Foreign
	Director		none	ILAM ZUF	69	Yrs.	monato bay	o modio	F	'eb. 5,	1934	Nig	eria
	land		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					1.	10d. Inside City Limits
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	ith the Marylan or 28a-f show se notified at	Director	10e. Street and Number			1 5	10f. Zip Code	•			10g. Citizen	of What Cou	ntry?
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	ier death w Items 23a	Funeral	11. Marital Status	Armed F		.S. 13.	Was Decedent of Yes, specify Co	f Hispanic Ori Jban, Mexicar	gin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	- 14. F	Race - Americ Black, White,	
36	urs att	by F	1 ☐ Never Married 2 ② Married 3 ☐ Widowed 4 ☐ Divorced	If Yes G	2 🔀 No live Dates:		1 ☐ Yes 2 🖾 N	o Specify:			Spe	cify:	lack
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	s 1 and 2 should be tiled within f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M	ဥ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	g Address (Stre	et and Numbe					
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ore.	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	20b. F	Place of Dispo cemetery, cren	sition (Name of natory or other p	lace)	Dat	9	20c. Location	on - City or To	own, State
A Pola	Pa Int		'4 □ Donation 5 □ Other (S	pecify)		oro Ce			2/6/20			, Nige	ria
Ball	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service	Licensee	all.	M 4	Name and Add arshall 217 9th	ress of Facility S Fund St. N	eral H .W. V	Home, Vashing	Inc. gton,	D.C. 2	0011
8760,	Medical Manager Manage	licai Examiner	skock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If my learn to mmediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Met Due to		uence of):	onco	ROTI	ζ	COL	Cino	mo	Approximate Interval Batween Onset and Death
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live	utcome of pregna birth 2 ☐ Feta gnant at time of c	ıl death 3 □	Ectopic pregnar Other (specify)	icy				Date of delive	ery Day Year
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CP	(10)	i	30. Name and address of person	who completed cau	use of death (Item	n 23a) (Type,	Print)	IVP	Bal.	timo	C = 1	NN ~	1737
	Sta	to	31. Date filed Month, Day, Year)	1060 [	O-N KIIIN Registrar's Signa	7 Que	NIE VI	IVE	1001	11/10	161	WV, 2	101/
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	/Medic		Elizabeth L.	Allen					01	09	04	6:05	A M
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er .	Funeral Director			M 2√xF 93	Yrs.	Months Days	Hours	Min.	(Month, Da 11 27	y, Year)		hington	
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	ther d	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No		Was Decedent of H If Yes, specify Cuba		Puerto P	Rican, etc.)		Black, Wh		
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/Medic Examin		4a. Fecility Name (If not institution, give str		4b. City, Town, or Location of Death	January	4c. County of Deat	
Funeral Director		377-30-3004	7. Age (In yrs. last birthday 1 2□ F 59 Yrs.	Seabrook    If Under 1 Year	8. Date of Birth (Month, Day, Y Aug. 2,	Prince Go (Par) 9. Bird 1944 Was	eorge's hplace (State or Foreign yntry) hington, DC
within 72 hours after death with the Maryland and and "A then "heturel", or Items 23a or 28e-f show than "heturel", or Items 23a or 28e-f show he Marical Examination and be notified at	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge  10e. Street and Number	orge's Seabroo		100	Citizen of lather Co	10d. Inside City Limits 1 X Yes 2 □ No
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should be and Mental is marked o	2	Willie Mae Bolin	Drivet 401 M 1		ary Port		
and 2 si ealth and n 27 is r		19a. Informant's Name/Relationship (Type Elaine Bolin - Spot		ing Address <i>(Street and Number or Rura</i> 3 Ogden Place, Seab			
Ly and Pa		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposoval from State		ate 20	c. Location - City or centwood,	Town, State
permit. Pages 1 ar Department of Hea Importent: If item any injury or othe once.		21. Signature of Funeral Service Licensee	Max 4	2. Name and Address of Facility Gaso 739 Baltimore Avenu	ch's Fune ie, Hyatt	ral Home, sville, M	P.A.
ate be executed  EXA  Wedician and he burial-transit  authority transit  authority transi	lical Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d		idure Nellitus	respiratory arrest.		Approximate interval Between Onset and Death  3 years we than 20 years
The law requires that the death certificate are has been signed by the attending phy page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delin	very Day Year
w requires that been signed b	þ	Part II. Other significant conditions contrib	outing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death? bably 4 ∑Unknown
	Completed	Cerebro Vascu	Terry Diseas	e	24a. Was an autopsy performed	prior to c death?	opsy findings available ompletion of cause of
this ld	ation: To Be	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	pital: 1  Inpatient 2  ER/Outpatier 28a. Date of Injury (Month, Day Year)			e 6 ∏Other (Special of the first of the fir	ify)
	Certification:	4 Homicide	28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, S		
To the Hospitel within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one)  1 ★ Certifying Physici 2 ★ Madical Examiner	<ul> <li>an: To the best of my knowledge, deat</li> <li>On the basis of examination and/or in and manner stated.</li> </ul>	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
Tot Com	2	29b. Signature and title of certifier	Mason 1	29c. License number	_	Date signed (Month) anuary 13	
		30. Name and address of berson who comp	ticut Aver	Print) rue, (tensin	cton	MDZ	2895
Stat Registra		31. Date filed (Month, Day, Year)  / JAN 1-6, 2004	32. Registrar's Signature	U			

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 03028

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumetic avant, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

1. De	cedent's Nam	e (First, Middle,	Last)								2. Date of D	eath	_		3. Time o	of Death
R	eginal	d Max	well B	utler	c						Janua	ry	11,20	004	2:0	OO AN
4a Fa	acility Name (/	f not institution,	give street and no	ımber)			707	14	4b. City, To	wn, or Lo	ocation of Dea	ıth	4c. County			
P	rince	George'	s Commun	ity H	losp	ital			Chev	erly	7		Princ	e Geo	rge's	3
5. So.	cial Security N 2-86-4	lumber 6	5.Sex 1⊠XM 2□F			est birthday) Yrs.	If Under 1 Ye Months Da		If Under Hours	-	8. Date of B (Month, D Nov. 2	av. Ye	ear)	9. Birthpla	ace (State on) Land	
Usua 10a.	Residence of	10b. County		1	Oc City	, Town or Lo	eation			-				10	d Inside C	Nitra I implica
	MD		George'			everly									d. Inside C	2 □ No
	Street and Nur 6002 R	mber eed Str	eet				10f. Zip Cod 2078					10g.	. Citizen of \	What Count USA	ry?	
11	arital Status ZNever Marri □ Widowed	ied 2 Marrie 4 Divorced	12. Was Dec Armed F d 1 ☐ Yes If Yes, G Year or I	orces? 2 (2XNo ive	erin U,S		Vas Decedent Yes, specify ( ☐ Yes 2 🔼		ispanic Ori an, Mexican Specify:	gin? (Sp ı, Puerto	ecify Yes or N Rican, etc.)	lo-	Blac	e - America ck, White, e · Blac	itc.	
Ele	(Spec		grade completed,	1-4or 5+)		16a. Deced (Give life. D	ent's Usual Ockind of work do OO NOT use re	cupa ne d tired	ation during mosi d)	t of work	ing	168	b. Kind of Bu	usiness/Indu	ıstry	
Lie	12	ridary (0° 12)	Conlege	1-401 547		Dis	abled						None			
17. Fa	ather's Name	(First, Middle, La	ast)						18. Mothe	r's Name	e (First, Middle	e, Mai	den Suman	ne)		
J	ohn Fr	ancis B	utler						Cat	heri	ine Lan	cas	ster B	utler		
		A. Bla	<sub>p (Type, Print)</sub> kney <b>,</b> Si	ster			g Address <i>(Str</i>									
1			B □Removal from		ce	metery, crem	sition (Name of atory or other cion Ce:	plac	•	1/	Date 20/04		Location -	•	,	
Imme disea	ediate Cause (	Final	omplications that only one cause on an an Int			Do not ente		dyin	g, such as	cardiac (	or respiratory a	arrest,		1	Approximat Interval Bet Onset and I	tween Death
resun	ting in death)			Du	e to (or	as a consequ	uence of):									
			■ ь. Нур	erter	nsio	n								1	8 Yea	ırs
Sequ if any cause	entially list cor , leading to im e. Enter Unde e (Disease or	nditions, mediate rlying	End			as a consequ enal I	uence of): Disease								7 Mon	iths
maun	nitiated events ing in death) L		C	Due	e to (or a	as a consequ	ence of):	-								and the second of the second o
Part II	. Other aignifi	cant conditions	s contributing to d	eath but n	ot result	ting in the un	derlying cause	give	en in Part I.		23b. Did	tobac	co use cor	ntribute to t	he cause o	of death
_	Menta	1 Retar	dation								1 🗆	Yes	2□ No	3 Proba	ıbly 4.⊠	Unknow
											24a. Was	s an ai	utopsy 1?	avail	e autopsy f lable prior to pletion of c eath?	to T
											10	Yes	2 X No	10	Yes 2□	No
25. W	as case referr	ed to medical								of Death	(Check only	one)				
	⊒Yes 2.2X	No	Hospital: 1	Inpatient	2 <b>₹</b> E	R/Outpatient	3□ DOA	Othe	er: 4□ Nui	rsing Ho	me 5□Resi	idence	e 6 □Othe	er (Specify)		
1	anner of Death ∑Natural □ Accident	5 Pending investigat		of Injury th, Day Ye	ear)	28b. Time of Injury	28c. li M		rat ∢? Yes 2 □ N		28d. Describe	how i	njury occurr	ed		
	☐ Suicide ☐ Homicide	6 Could not determine	ad 289. Place	of Injury ing, etc. (5	- At hom Specify)	ne, farm, stre	et, factory, offi	се		:	28f. Location ( City or To	(Street wn, St	t and Numbe tate)	er or Rural I	Route Num	iber,
	Certifier (Check only one)	1 ☑ Certifying i 2 ☐ Medical Ex	Physician: To the aminer: On the b and man	best of m asis of exa ner stated	aminatio	ledge, death on and/or inve	occurred at the estigation, in m	tim y op	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause date	e(s) and ma and place, a	nner as stat and due to ti	ed. he cause(s	;)
29b. 9	Signature and	title of certifier					29c. Lice	ense	number			29d	Date signed	(Month. Da	av. Year)	

D 59812

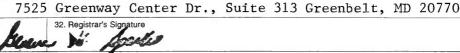
29d. Date signed (Month, Day, Year)

January 12, 2004

State Registrar 31. Date filed (Month, Day, Year) JAN 1 6 2004

Wei Lu, MD

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

				State of Maryland / D	Departr	nent of Hea	Ith and Mo	-	_	03029
		1	For State Registrar		Certifi	cate of De			g. No.	
	Physicia	ın	n. Decedent's Name (First, Middle, Last) Helen I.ouise Barr					2. Date of Death Month January	Day Year	3. Time of Death 1:00P M
	/Medic Examin	er <sup>4</sup>	la. Facility Name (If not institution, give si			. City, Town, or Loc			4c. County of Death	
Н			Millennium Health&			ort Washi	_		Prince Geo	0
	Funeral Director		191 01 0910	M 257F 91			Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, 12/23/1	Year) 9. Birthy 912 Texa	place (State or Foreign htry) 1S
	show		Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge	orge's Fort W				·		10d. Inside City Limits 1 ☐ Yes ※XNo
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Importent: If item 27 is marked other than "neturel", or Items 23e or 28a-f show any injury or other traumatic event, Ite Medical Examination that the modified at once.	irect	10e. Street and Number 8511 Rose Marie Dr		1	Of. Zip Code 20744		10	g. Citizen of What Coul	ntry?
	sath v	era		2. Was Decedent Ever in U.S.	13. Was		nic Origin? (Spe	cify Yes or No-	14. Race - Ameri	can Indian,
36	rsafterde i', orttөл	oy Fun	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Decedent of Hispars, specify Cuban, M	exican, Puerto F pecify:	Rican, etc.)	Black, White, Specify: Whi	
응	ture sture	ed	15. Decedent's Educ	ation 16a.	. Decedent	's Usual Occupation			6b. Kind of Business/In	dustry
21215-0036	within 72 ane. than ne	Completed	(Specify only highest grade	Completed) College (1-4or 5+)	Give kind life. DO ecret	of work done during NOT use retired)	g most of workir		Oil Industr	`v
	filled Hygir Sther ent, I	ပိ	17. Father's Name (First, Middle, Last)				Mother's Name	(First, Middle, M		
Maryland	id be lental ked c	To Be	William Millikin				Maude	Kenned	V	
аZ	should by and N s mail	-	19a. Informant's Name/Relationship (Type	pe, Print) 19b	. Mailing A	ddress (Street and I	Number or Rura	Route Number,	City or Town, State, Zip	o Code)
	and 2 salth a n 27 i		Kathy Hunter/Niece		11 Rc	se Marie	Dr. For	t Washi	oc. Location - City or To	0744
Ore	of He of He fiten		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 \(\tilde{\text{L}}\) Re	cemete.	ry, cremato	ry`or other place)				
Ĕ	Pag ment ent: f		`4 □Donation S □Other (Specify)	Cross		s Cemeter			Cross Plain	
Baltimore,	permit. Departimport any inj		21. Signature of Funeral Service License	6/11	6160	Oxon Hil	1 Rd. 0	won Hill	Funeral Ho l, Md. 2074	
	Physician /Medical Examiner		23a. F.M. Enter the disease or complishock, or heart failure. A ist only on Immediate Cause (Final disease or condition resulting in death)	Carry's hat caused the death. Do en us on each line.  Gastrointestin  Due to (or as a consequence	ar Ri	ne mode of dying, su eeding	ich as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
,60,	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence		_				
92	ite be lysicia ne bu	icaj		l,						
O. Box 687	he death certificate be execu r the attending physician and ched for use as the buriat-tra	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		topic pregnancy her (specify)			23d. Date of deliv Month	ery Day Year
ds, P.O.	requires that the de een signed by the a nould be detached t		Part II. Other significant conditions cor	stributing to death but not resulting i	in the unde	rtying cause given in	ı Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to l s 2 ∰No 3 ☐ Pro	the cause of death?
Division of Vital Records,	The law requir ate has been si page 2 should I	Completed						24a. Was an autopsy perform	/ prior to co	opsy findings available ompletion of cause of
a	icien: Th certificate rector, pag	ပိ	25. Was case referred to medical			26	Place of Death	(Check only one		20110
Ē	Physicien: this certific	0 B	eyaminer?	lospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient				nce 6 Other (Speci	fy)
on of	nding Phys th. : After this s funeral di	tlon; T	27. Manner of Death  1XXNatural 5 Pending 2 Accident investigation		Time of Injury	28c. Injury at Work?			w injury occurred	
Divisi	l or Attendil after death. Director: A	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street	, factory, office		28f. Location (Str City or Town	reet and Number or Rui , State)	al Route Number,
	Hospita 4 hours Funeral	Medical C	29a. Certifier (Check only one)  1 Certifying Phy: 2 Medical Exami	sician: To the best of my knowledg ner: On the basis of examination at and manner stated.	ge, death oo nd/or inves	ccurred at the time, of tigation, in my opinion	date and place, a	and due to the ca	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier  William ()	unu n		29c. License nu D35206	imber		3d. Date signed (Month) $1/8/2004$	Day, Year)
L (	3)		30. Name and address of person who co William T. Tanner	,M.D. 11701 Livi	ngsto	on Rd. Ft.	Washin	gton,MD	. 20744	
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 4 2004	2. Registrar's Signature	foods					

			1 - For State Registrar	State of Maryland / D	Department of Health  Certificate of Death	and Mental Hy					
	Physici /Medio Examin	cal	Decedent's Name (First, Middle, Last     BEN     Aa. Fecility Name (If not institution, give	BROWN	4b. City, Town, or Location	2. Date of De Month 1 10	2004 S:35 P M				
	Funeral Director	161	410-30-7171	7. Age (In yrs. last birt	LANHAM  hday) If Under 1 Year If Under 1 Year Months Days Hours	r 24 Hrs. 8. Date of Bir Min. (Month, Di August	PRINCE GEORGE'S  th year, 24 1932 PARAMA  PRINCE GEORGE'S  9. Birthplece (State or Foreign Country) ALABAMA				
1215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or Iteme 23a or 28a-f show event, the Middical Examiner must be nutilised at	Director	Usual Residence of Decedent		WIE  10f. Zip Code  207.20		10d. Inside City Limits  1\\times Yes 2 \subseteq No  10g. Citizen of What Country?  U.S.A.				
	hours after death tural', or Iteme 23	d by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 17274es 2 No ARMY If Yes, Give Year or Dates:	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica  1 Yes X No Specify						
	ed within 72 h gjene. er than "natu . Ine Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th	de completed)  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired) METRO BUS OPERAT	OR	16b. Kind of Business/Industry PRIVATE				
ıryıand	should be filed ind Mental Hygis marked other umatic event, II	To Be (	17. Father's Name (First, Middle, Last)  WATT BROWN  19a. Informant's Name/Relationship (7)	, Maiden Surname)  CSON  er, City or Town, State, Zip Code)							
ore, mar	pes 1 and 2 of Health a of Item 27 is		JESSIE Y. BROWN/W  20a. Method of Disposition 1∑ Burial 2 □ Cremation 3 □	IFE 42  20b. Place of cemeter,	01 GLENDALE ROAL Disposition (Name of y, crematory or other place)	Date	20c. Location - City or Town, Stete				
Baltimore,	permit. Pages Department of Important: If it sny injury or o		*4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licenses		22. Name and Address of Faci		CHELTENHAM, MARYLAND NS FUNERAL HOME VER, MARYLAND 20785				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		CARDIAL INFARCT		rrest. Approximate Interval Between Onset and Death				
1/en,	eath certificate be executed attending physician and for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. First and onlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of d.	ue to (or as a consequence of):						
O. BOX 68	at the death certifical by the attending phi fached for use as th	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		23d. Date of delivery Month Day Year					
ecords, P.	The law requires that the death tie has been signed by the atter bage 2 should be detached for u	by P	Part II. Other significant conditions or	obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown							
Vітаї Жесі		e Completed	25. Was case referred to medical		00 Ple	1 Tes	psy prior to completion of cause of death?  1 Yes 2 No				
O1 V	Phy this ald	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ R/Out 28a. Date of Injury 28b. T	tpatient 3 DOA Other: 4 N		dence 6 □Other (Specify) how injury occurred				
VISION	or Attending ifter death. Director: After in by the fune	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year)	Street and Number or Rural Route Number, wn. State)						
	To the Hospitel or within 24 hours afte To the Funeral Direction completely filled in It	Medical Co	29a. Certifier 1 Certifying Phyone 1 Certifying Phyone 2 Medical Example 1	ysician: To the best of my knowledge iner: On the basis of examination and and manner stated.	Vor investigation, in my opinion, de	nd place, and due to the ath occurred at the time,	date and place, and due to the cause(s)				
	To the I within 2. To the I complet	W	29b. Signature and title of gentitie	4023/1l	29c. License number		29d. Date signed ( <i>Month, Day, Year</i> )				
	Sta	ate	30. Name and address of person/who of YE1+EY1S NEGW 31. Date filed (Month, Day, Year)	completed cause of death (Item 23a) ( 55 IE 4404 QUEE)  32. Registrar's Signature	Type, Print) USBURY ROAD SO	11TE 104 1	RIVERUSALE NS 20237				
-21	Regist	rar	IAN 4 4 200/								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2004 8 1:55 A JAMES BENSON Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1√2 M 2□ F 85 Yrs. Director 250-05-7306 SOUTH CAROLINA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State s 23a or 28a-f show cust be notified at TYDYes 2 ☐ No Directo PRINCE GEORGE'S FORT WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20744 13003 CHALFONT AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status The Medical Examiner of 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No BLACK þ 3 XWidowed 4 ☐ Divorced \*natural\*, Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT PLASTER 12th of Health and Mental Hygistem 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) BENSON SR. ELOUIS LOMAX JAMES Α. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13003 CHALFONT AVENUE FORT WASHINGTON, MD 20744 19a. Informant's Name/Relationship (Type, Print) RASHED HOWARD/CARE-TAKER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges 1
Department of HImportant: If iter
any injury or oth 1 Burial 2 Cremation 3 Removal from State 1-15-2004 ROCKVILLE, MARYLAND PARKLAWN CEMETERY \* 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Ligensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCHEROTIC CARDIOVASCULAR **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exam Due to (or as a consequence of): sician a Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by CARDIOMYOPATH 3 ☐ Probably 4 ☐ Unknown FAILURE 1 ☐ Yes 2 ☐ No RESPIRATORY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 NO Severe PARKINSONS 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖼 🔨 🗸 1 Minpatient ဥ 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHYSICIAN 53782 JAN 08 DURESH VERGHESE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VERGHESE LIVINGSTON ROAD, SUITE#101 FT. WASHINGTON 11701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

7/20/1918

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				epartment of Health and M Certificate of Death	lental Hygier	2004 0303/						
	Physici /Medic		Decedent's Name (First, Middle, Last)     TANDY BRYANT	2. Date of Death Month Jan. 7,	Day Year 3. Time of Death 2004							
	Examir		4a. Fecility Name (If not institution, give street and number) Washington Adventist Hospita			4c. County of Death Montgomery						
	Funeral Director		5. Social Security Number 425-11-3015 6. Sex 7. Age (In yrs. last birth 45 Yr. Usual Residence of Decedent	Administration Design Marian Admin	8. Date of Birth (Month, Day, Yes Jan. 27,	9. Birthplace (State or Foreign Country) 1958 Mississippi						
	Maryland	tor	10a. State 10b. County 10c. City, Town	or Location pital Heights		10d. Inside City Limits 1 □3XYes 2 □ No						
	th with the 23a or 28e ist be noti	al Director	10e. Street and Number 910 57th PLace	10f. Zip Code 20743	10g.	Citizen of What Country?						
, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. bd other than "natural", or tiems 23a or 28e-f ehow event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☑ XNo  If Yes, Give  Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto     □ Yes 2☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black						
	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  Q	Decedent's Usual Occupation Give kind of work done during most of worki ife. DO NOT use retired)  Construction	ing	Kind of Business/Industry						
	should be filed within and Mental Hygiene. is marked other than 's aumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) William Bryant	18. Mother's Name	e (First, Middle, Maid	ollege Park Pavin <sup>en Sumame)</sup> Holloway						
	nit. Pages 1 and 2 should artment of Health and Men ortent: If item 27 is marke injury or other traumatic g.		Annie Baldwin-Sister 91	Mailing Address (Street and Number or Rura 0 57th St.Capital Disposition (Name of	l Hgts,M	D.20743						
Baltimore,	permit. Pages. Department of the Importent: If its eny injury or of once.		1 Puriol 2 Comption 2 Permanul from State cemetery,	Spring Cem Jan	.16,04 W							
Ba	permi Depa Impo eny ii		908 Kennedy St. N. W. Wash. D. C. 20011  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest.  Approximate									
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of)	tic Coronary An	1	Oncet and Death						
8760,	ficate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, toading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of)									
.O. Box 687	death certit e attending d for use a	Physician/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year						
Δ.	.≡ v 70	þ	þ	Part II. Other significent conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?  2 🗆 No 3 🗆 Probably 4 🖫 hknown					
Vital Records,	(0	Completed			24a. Was an autopsy performed?							
Division of Vita	To the Hospital or Attanding Physician: Th within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	To Be	Be	25. Was case referred to medical examiner?  1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outp.  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm building. etc. (Specify)	ne of 28c. Injury at 2 ury Work? M 1 Tyes 2 No	me 5 Residence 28d. Describe how in	and Number or Rural Route Number.					
	the Hospital or Attendin 24 hours after death the Funeral Director: npletely filled in by the		4 ☐ Homicide building, etc. (Specify)  29a. Certifier (Check only 2 ☐ Medicel Exeminer: On the basis of examination and/o	death occurred at the time, date and place, a	City or Town, Sta	(s) and manner as stated.						
	To the half within 24 To the F	Medical	29b. Signature and title of certifier  X  X  X  X  X  X  X  X  X  X  X  X  X	29c. License number 5 Z 3 Z 6		Date signed (Month, Day, Year)						
)_	(1)		30. Name and address of person who completed cause of death (Item 23a) (Ty James Lightfoot, M.D. 7600 Ca		Park,Md	.20912						
	Sta Registr	_	31. Date filed (Month, Day, Year)  AN 1 3 2004  Registrar's Signature	rack)								

	1	For State Registrar	State of Maryland		rtment of H		•	giene Reg. No. 200	4 03033	
ician dica	1	1. Decedent's Name (First, Middle, Last) Barbara		Bric	e- Bro	wn	2. Date of Dea Month	, Day Yea	3. Time of Death	
ine	r 4	In Facility Name (If not institution, give some facility Name (If not institution, give some facility Name of the facility Number facility Number facility Name (If not institution, give some facility Name (If not institution), give some facility Name (If not institutio	PKins HosPit	La L st birthday). Yrs.	4b. City, Town, o  Call Hill  If Under 1 Year  Months Days	r Location of Death  ORC  If Under 24 Hrs.  Hours Min.		4c. County of De	eath Sirthplace (State or Foreig Country) NNESSEE	
		Jsuel Residence of Decedent 10a. State 10b. County		Town or Loc					10d. Inside City Limit:	
Director		IARYLAND   PRINCE GE 10e. Street and Number .6254 BROOKTRAIL CO		ER MAR	10f. Zip Code	0772		10g. Citizen of What		
hy Europeal	Laune		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ※ XXNo If Yes, Give Year or Dates:			lispanic Origin? (S an, Mexican, Puert Specify:				
Completed b	mpiered	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give l life. L	DO NOT use retired	during most of wor d)	king	16b. Kind of Business/Industry		
To Be Co	a e	17. Father's Name (First, Middle, Last) ERNEST BRICE, JR.	5+	SE	INIOR ATT	18. Mother's Nan	ne (First, Middle,	GOVERNMI Maiden Surname)	LNT	
		19a. Informant's Name/Relationship (Ty, GREGORY BROWN (HUS	BAND)	16254	BROOKTR			er, City or Town, State		
h		20a. Method of Disposition  1. Description 2 □ Cremation 3 □ R  `4 □ Donation 5 □ Other (Specify)	emoval from State OAK	netery, crem RIDGE	sition (Name of natory or other place NEM . PA	RK JAN.	Date 10,2004		GE, TN	
		21. Signature of Funeral Service License	elel l	143	308 SUITL	AND ROAD	SULTL	MARYLAND,	)/46	
1		23a. Part1., Enter the disease, or complishock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused had death. the cause on each line.  Due to (or as a conseque		er the mode of dyin	ig, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death  A Aay S	
dicai Evaminar	Exam	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	mia					( day	
veicion/Mad	Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d. Date of o	delivery Day Year	
2	2							l tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknow		
Complet	Completed						24a. Was autop perfo 1  Yes			
F	0	25. Was case referred to medical examiner?  1  Yes  2 No		R/Outpatien 8b. Time of Injury	28c. Injur Wor	er: 4 □ Nursing H y at		one) dence 6 □Other (S) now injury occurred	pecify)	
Sorbibles	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	eet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Jiooibo	edicai		sician: To the best of my knowl ner: On the basis of examinatio and manner stated.							
100	≥	29b. Signature and title of certifier  Para Jolan  30. Name and address of person who co  Sara Tolaney, Joh	ey, MD		29c. Licens			29d. Date signed (Mo Jan uary		
			-							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dev Veer **Physician** 04:15 PM 21 GLADYS BACKOFF JAN. 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner CECIL UNION HOSPITAL ELKTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 89 DELAWARE OCT.11,1914 222-44-6146 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show of 2 should be filed within 72 hours after death with the Maryla lith and Mental Hygiene. 27 is marked other then "natural", or iteme 23a or 28a-f ehov treumatic event, the Medical Examinatings installed at 1 Yes 2 □ No Director NEW CASTLE NEWARK 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21 E. PARK PLACE 19711 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 11th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WILLIAM M. SARTIN MALVINA WALTERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is eny injury or other traconce. 17 E. PARK PLACE, NEWARK, DE 19711 ESTHER M. BURRIS - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
Head of Christiana 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State JAN. 26. 04 NEWARK, DE. 1 4 ☐ Donation 5 ☐ Other (Specify) Cemetery SPICER MULLIKIN FUNERAL HOMES, INC. 1000 N. DUPONT PKWY., NEW CASTLE, DE 23a. Part 1. Enter the disease, or complications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. 19720 **Approximate** Interval Between Onset and Death Immediate Cause (Final Preumonia Unknows **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): avoric Obstructive Pulmonary Disease Tenknows Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day ò 4☐Pregnant at time of death 5 Other (specify) 1 Yes signed by the a d be detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Deep Venous Twombophlebitis 1 Yes 2 No 3 Probably 4 Unknown Completed Epidural Abscess 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b rector, page 2 sl autopsy performed 1 Yes 2 ₹No To the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only ane) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0023322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S. SACHDER MD, 18 North St. Suite 18 North St Suit 3B Elekton MD21921 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 3 2004 Registrar

		•	1 - For Stete Registrar	State of Ma		nd / Depa	artme		ealth an		ntal Hygi		004	0303	
	nysicia Medic xamin	al	1. Decedent's Name (First, Middle, La.	street and number)	D (2			y, Town, or	Location of D		Date of Death Month	Day /2 4c. County	Yeer OOG y of Death	3. Time of Death	
Dire	neral ector		5. Social Security Number 6. S	9x 7. Ag		last birthday) Yrs.		er 1 Year	If Under 24 Hours	Min.	Date of Birth (Month, Day,	Yeer)	9. Birthpl Count	ace (Stete or Foreign try) ryland	
permit. Peges I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Manial Hygiene.	the notified at	Dire	10a. State 10b. County  Maryland Wicomi  10e. Street and Number  6658 Brick Kiln		10c. Ci	ty, Town or Lo	ury	ip Code 2180]			10	g. Citizen of USA		od. Inside City Limits 1 ☐ Yes 2 ☑ No	
ours after death	Examiner mus	by Funeral	11. Marital Status  1 Never Married 21 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates:	No		_		spanic Origin' n, Mexican, P Specify:	? (Specify uerto Ric	y Yes or No- an, etc.)	14. Rad	ce - America ck, White, e		
filed within 72 h Hygiene.	nt, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	(Give	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  arts mgr/purchasing agent  18. Mother's Name (First, Midd					16b. Kind of Business/Industry  Meadows Hydrauli					
Maryiania 2.12.13-0036 d 2 should be filed within 72 hours at the and Mental Hygiene.	trsumatic eve	To Be	Harry Clay Baile  19a. Informant's Name/Relationship ( Edna E. Bailey/wi	уре, Print)					Haze	el El	izabetl	oeth Adkins  mber, City or Town, State, Zip Code)  Sbury, MD 21801			
Darrimore, Noemit. Peges 1 and Department of Health	njury or other	31	20a. Method of Disposition  1 23 Burial 2 Cremation 3 4 Donation 5 Other (Specification 2). Significant Control of Service Licer	Removal from State	(	Place of Dispo cemetery, crer .Stephe	sition (A natory o	ame of other place Cemete	ery ]	Date 1/14/	/04	oc. Location of Delmar	City or Tov	vn, State	
	- 75 3	1	by and	מממן	FS I the deat	th. Do not ent	O1 S er the m	now E	ill Rd g, such as car	., S	alisbu	y, MD	21804	Approximate Interval Between Onset and Death	
e be executed	dical	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as  b. Due to (or as  c. Hyp.  Due to (or as  d. Type	a consec a consec ever	uence of):	eles	ide		can	tid a	ilory		13/04 years years years	
To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours after death.  To the Funareal Director: After this certificate has been stoned by the attending only	ached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	ıl death 3 □	Ectopic Other (	pregnancy specify)				1	te of deliver	y Day Year	
he law requires that	should be detached f	eted by Pi	Part II. Other significant conditions o	entributing to death b	ut not res	ulting in the u	nderlying	cause give	n in Part I.	_		2 No	ribute to the	cause of death?	
vicion: The law	3 (4	Be Completed	25. Was case referred to medical		OS Please of December			autopsy prior to performed? death?		prior to com	sy findings available pletion of cause of				
l or Attending Physici after death.	9	2	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 x Inpatie 28a. D. te of Inju (Month, Daj		ER/Outpatien 28b. Time of Injury		28c. Injury Work	1: 4 Nursin	ng Home	5 Residen	ce 6 □Oth			
spitel or Attendours after death	filled in by th	al Certification:	3 Suicide 4 Homicide  6 Could not be determined							i	City or Town,	State)		Route Number,	
To the Hospite within 24 hours	completely	Medical	(Check only 2 Medical Exam one)  29b. Signature and title of certifier	iner: On the basis of and manner sta	examina	ation and/or inv	estigation 2	n, in my op 9c. License	inion, death o	occurred a	it the time, dat	d. Date signed	and due to t	he cause(s)	
DQ DQ	Sta eģistr	-	30. Name and address of person who Inju Hulang 31. Date filed (Month, Day, Year)  JAN 1 4 2	ompleted cause of d	P	n 23a) (Type,  0 Bo)  ature	Print)	18,5	salisb	ury	, mg	218.	72		

		1	For State Registrar	State of Maryland /		ırtment <i>tificate</i>			ind Me		giene 1eg. No.	004	03036		
			Decedent's Name (First, Middle, Last)						1	2. Date of Dea Month	ith Day	Year	3. Time of Death		
	Physicia /Medic		HERBERT G. BALL 01 1								17	2004 ounty of Death	7:20 P M		
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea												
			5596 POWELLVILLE RO		If Under	ILLA		24 Hrs	P Date of Birth		WICOMI				
	Funeral		5. Social Security Number 6. Sex	M 2□F 7. Age (In yrs. last b	Yrs.	Months	Days	Hours	Min.	B. Date of Birth (Month, Day 3-20-19	7, Year)		place (State or Foreign htry) , MARYLAND		
	Director	-	218-12-1294 The suit of December 1 The suit of December 2 The suit o	00						J-20 1.	723				
	land 10w		10a. State 10b. County	10c. City, Tov	wn or Lo	cation						1	10d. Inside City Limits 1 ☐ Yes 2 🗓 No		
	Mar Mar	tor	MD WICOMICO WILLARDS  10e. Street and Number 10f. Zip Code 10g.												
	or 28	Funeral Director								10g. Citize	n of What Cou	ntry?			
	ath w 23a	ral	5596 POWELLVILLE RO		40.1	W D	_	21874	-in2 (Coo	of y Voc or No	14	USA . Race - Ameri	can Indian		
	er de	nne	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?     ↑ □ Yes	13.	f Yes, spec	ify Cuba	n, Mexican	, Puerto P	ify Yes or No- lican, etc.)		Black, White,			
99	rs aft	by F	1 Never Married 2 Married  3	If Yes, Give Year or Dates:		1 🗆 Yes 💈	2 <b>X</b> No	Specify:			S	pecity: WE	IITE		
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23e or 28e-f show the Medical Examinat Francilled at	per	15. Decedent's Educ		a. Deced	dent's Usua	I Occup	ation during most	t of workin		16b. Kind	of Business/In	dustry		
212	hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	se retired	))	or working	9					
N	er the	Completed		5+	SCHO	OL PR	RINC		d- Nome	(Fire & Adiatella		ATION S	SYSTEM		
2	be file tal Hy d oth avant	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maidell St	umame)			
<u>\Z</u>	2 should be filed within and Mental Hygiene. Is marked other than "rearmatic avant, the Med	ပ္	CHARLES GLADSTONE BALL  19a Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Re								The state of the s				
Maryland	12 sh h and 7 ls m traum		19a. Informant's Name/Relationship (Typ									RYLAND			
ത്	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene I Health and Mental Hygiene I Health and Mental Hygiene I Ham 27 is marked other train "natural", or Itams 23a or 28a-1 show than traumatic avant, the Medical Examinatic matter milliad at	-	JAMES H. BALL - SOI	20b. Place	of Dispo		ne of			ate WILLIAM		tion - City or T			
Baltimore,	permit. Pages: Department of H Important: If Its any injury or of		1 ☑Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State					1-22-	2004	WILLA	RDS, MA	RYLAND		
薑	ortar injur		21. Fignature of Funeral Service License									HOME, I			
m	Department		H Jenso	& Keller								Y, MARY	LAND 21804		
All as	1. (2 19		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do	not ent	er the mod	le of dyin	g, such as	cardiac or	respiratory ar	rrest,		Approximate Interval Between Onset and Death		
1.6	Physician		Immediate Cause (Final disease or condition			Co	20mi	R of	Lu	rs			month		
937	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):										
	Lxammer	L.	Sequentially list conditions, if any, leading to immediate	. Due to (or as a consequenc	e of):										
	ted nsit	nine	Cause (Disease or injury	200 10 (0. 20 0.00)	,										
_^	be executed sician and burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence	e of):										
760,	ate be executed hysician and the burial-transit	call		l,											
68	tificat ng ph) as th		The second secon												
Вох	death certifica e attending ph d for use as th	an/N	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea		Ectopic p		,			23	3d. Date of deliving Month	rery Day Year		
		Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5	Other (sp	oecify)				9)				
P.0	The law requires that the de ate has been signed by the a bage 2 should be detached to		Part II. Other significant conditions con	stributing to death but not resulting	g in the u	inderlying o	ause giv	en in Part I	l.	23e. Did t	obacco use	e contribute to	the cause of death?		
ds,	uires t signe Id be (	d by	Lean D							10	Yes 2	Mo 3□Pro	bably 4 Unknown		
20	w requ been shoul	lete			24a. W						has an 24b. Were autopsy findings available				
Vital Record	The lav	Completed								autor perfo	psy ormed?	death?	ompletion of cause of		
tal		a	25. Was case referred to medical	26. Place of Death Check on one											
<u>&gt;</u>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	lospital: 1   Inpatient 2   ER/	Outpatie	ent 3 DOA Other: 4 Nursing		ursing Hor	ne 51 Hesi	dence 6	Other (Specify)				
of	ding Ph h. After th funeral	0.01	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28t (Month, Day Year)	. Time o	of :	of 28c. Injury Work			8d. Sescribe	how injury	occurred			
<u>Si</u>	sndii eath. or: A the fu	cati	2 Accident investigation		,	М		Yes 2		19f Leastion /	Stroot and	Number or Pu	ral Route Number,		
Division	or Att fter d Sirect in by	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	tarm, st	reet, factor	у, опісе		· ·	City or To	wn, State)	realition of rial	a rioute rumber,		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physical Certification Physica	sician: To the best of my knowled	dge, dea	th occurred	at the ti	me, date ar	nd place.	and due to the	cause(s) a	and manner as	stated.		
	8 Hos 24 hc 9 Fun etely 1	edical	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	and/or in	nvestigation	n, in my	pinion, dea	ath occurre	ed at the time,	date and p	place, and due	to the cause(s)		
	ro the	Me	29b. Signature and title of certifier	\				se number				signed (Month	, Day, Year)		
		1	> hubble	00			256	60			1.30	P0.2			
	10 14	1	30. Name and address of person who co	ompleted cause of death (Item 23	а) (Туре	, Print)	_	01-1		L.A. >	(2m1				
	1 1,		ME Croud	105 Pine Blue	# Co	24. 248	1,	701176	onn	, 50	1001				
W.	St	ate	31. Date filed (Month, Day, Year) 2	32. Registrar's Signature	2	A	par	Est							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 8 200 **Physician** muar Alimyon C. Brown /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Stella Maris Hospice Baltimore None 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral Months 1 ☐ M 2 ☒ F 42 244-45-1006 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene.
7 is marked other than "natural", or flems 23e or 28e-f show traumetic event, the Medical Examiner must be notified at 1 ☑Yes 2 ☐ No HLIMJOR Directo Maryland Anne Arundel Millersville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 8302 Watermill Drive 21108 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Filipina ٤ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cotlege (1-4or 5+) Elementary/Secondary (0-12) HomeLand security Security 12th 2 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be parmit. Pages 1 and 2 should be fi Department of Health and Mental h Important: If Nem 27 is marked out eny injury or other traumatic ever once. Valentina Unajan Juan Bangcot 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Francis Brown (Husband**)** 8302 Watermill Dr. Millersville, Md. 21108 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran 20a. Method of Disposition

13 □ Removal from State 20c. Location - City or Town, State Maryland Cometery 1/23/04 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Sons MOrtuary, P.A. 23a. Part1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physicien: The law requires that tha death certificate be executed attanding physician and for usa as the burial-transit Due to (or as e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Division of Vital Records, P.O. Box 68760, that initiated events Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? ata has been signed by the a page 2 should be detached to Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part It. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Be Completed completion of cause of death? TLYes 2LING 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6-Dother (Specify) hospice edicai Certification: To 1 Yes 2 No 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Deeth Injury 1-Naturel 5 Pending nours after death.

nerel Director: Aft
filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature and title of certifier SQ. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Baldimore Risebera PAUL JAN 2 3 2004 31. Dete filed (Month State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

		1	For State Registrar	State of Maryla		artment of rtificate of			iene <sub>eg. No.</sub> 2	004	0303
Pl	hysicia	n	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic xamin	al s	Joseph Edwin Busins! Na. Facility Name (If not institution, give str Anne Arundel Medica.	eet and number)		4b. City, Town, Annapol	or Location of Deat	January	4c. Cou	2004 inty of Death Arund	
	neral ector		5. Social Security Number 6. Sex 1XD N	7. Age ( <i>ln yr</i> s	. last birthday) Yrs.	If Under 1 Yea Months Days			Year) 1939	9. Birthi Cou Mary	
ryland	T at		Usual Residence of Decedent  10a. State 10b. County		ity, Town or Lo						10d. Inside City Lim
the Ma	notifie	ري ا ا	Maryland Queen Anne	316	VEIIS VI	10f. Zip Code			l0g. Citizen	of What Cou	ntry?
h with	38 or	Oie	301 Talbot Road			21666		U	nited	State	s
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	or flems	_		2. Was Decedent Ever in Armed Forces? 1		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N	Hispanic Origin? (S ban, Mexican, Puer o Specify:	pecify Yes or No- to Rican, etc.)		Race - Ameri Black, White, e <i>cify:</i> Whi	etc.
<b>215-0036</b> Ithin 72 hours af	n natural Medical Ex	Completed b	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occi kind of work don DO NOT use retii	e during most of wo	rking	16b. Kind o	of Business/Ir	dustry
21.2 bd with	E th	E C	12		Comme	rcial Wa				Employ	ed
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Via Ould t	harke hatic		Joseph F.J. Businsk		10h Madi	na Address /Ctra	Cora Ten	pest Ste		wn State Zi	n Code)
Mar 12 sh h and	7 is r traur		19a. Informant's Name/Relationship (Type		large min						
Tanc Healt	em 2	1	Deborah Businsky / 20a. Method of Disposition	Wife 20b.	Place of Dispo	albot Ra osition (Name of	1	ensville Date	20c. Locati	on - City or T	own, State
ages ont of	t: If it y or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State		matory or other p e Cremat		/2004	Bal ti	no re,	Maryland
Baltimore, permit. Pages 1 a Department of Hee	Importan any injur once.		21. Signature of Funeral Service Mcenser		2:	2. Name and Add	ress of Facility Jo	hn M. Ta	ylor :	Funera	1 Home,
Phys	sician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition	ations that caused the de cause on each line.	1 .		ying, such as cardia		rest,		Approximate Interval Between Onset and Death
/Me	edical		resulting in death)	Due to (or as a conse							
Exam	miner		Sequentially list conditions, b.	Due to for an a cons	nguenee of						
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Box 6	attending for use as	Physician/Med	in the past 12 months?  1 ☐ Yes 2 ☐ No	lc. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	etal death 3	□Ectopic pregnar □ Other (specify)	ncy		23d	. Date of delive Month	rery Day Year
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Division of or Attending after death.	To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe				28f. Location (S City or Tox		lumber or Ru	ral Route Number,
Hospita     A hours	e Funeral letely filled	lical	(Check only 2 Medical Examin	ician: To the best of my ker: On the basis of examinand manner stated.	ination and/or i	nvestigation, in m	y opinion, death occ	urred at the time,	date and pla	d manner as ace, and due	stated. to the cause(s)
To the within	To th compl	Me	29b. Signature and title of certifier  30. Name and address of person who co.  LISA A D MARZIG  31. Date filed (Month, Day, Year)			29c. Lice	D38158		29d. Date s	igned (Month	
			30. Name and address of person who co.	mpleted cause of death (I	tem 23a) (Type Ledicul	Perkwar	1, Surta 10	o Anap	لم إنار	22 0°	1401
*	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Redistrar's Sig	gnature	docute)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Elwanda Mull Barchi 19, 10:30 A<sup>M</sup> January 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 14 Sargent Court Annapolis If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Pay, Year) Nov. 10, 1942 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 61 Nov. North Carolina 244-64-7308 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28e-f ahow any injury or other traumatic avent, the Medical Experimentary to other traumatic avent, the Medical Experimentary. 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Sargent Court 21403 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Garland F. Mull Jo Rudisell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Barchi/daughter 1593 Lodge Pole Court Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/22/2004 Alexandria, Virginia 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) torioscleratic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 2 VNo 25. Was case referred to medical examiner?

1 √Yes 2 □ No completely filled in by the funeral director, 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Matural 5 Pending 1 Yes 2 No 2 Accident investigation within 24 hours after deatl To the Funeral Diractor: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 2 29b. Signatur and title of certifier death (Item 23a) (Type, Print) me and address of person who completed cause HMERICA Ct. 21035 MAMA m Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth January 20, 2004 **Physician** 3:23PM Buccelli Nina /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Charles Charles County Nursing & Rehab Center LaP1ata 7. Age (In yrs. lest birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 New York **Funeral** 1 M 2 F Days Yrs. Director 579 07 5988 Usuel Residence of Decedent Hygiene. other than "natural", or fems 23a or 28a-f show ent, the Madical Exeminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1☐ Yes 21 Tho Director permit. Peges 1 end 2 should be filed within 72 hours efter death with the N Depertment of Health end Mentel Hygiene. Important: If item 27 ie merked other than "mortant other traumette." Maryland Charles Waldorf 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2706 Moran Drive 20601 United States Funerai 12. Was Decedent Ever in U,S Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ ★ o If Yes, Give XX Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ThNo Specify Specify: Be Completed by 3 ₩idowed 4 □ Divorced White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrator Secretary Realty Title Ins Company 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Antoinette Trombino Felice Bianco 19a. Informant's Name/Relationship (Type, Print) (Children)

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Nina Hudson &Gene Buccelli d 2706 Moran Drive, Waldorf, Maryland 20601 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan 28,2004 Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland Lee Funeral Home, Inc. 21. Signature of Funeral Service License 22. Name and Address of Fecility 6633 Old Alexandria Ferry Road Clinton, MD20735 100153 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner nding physician end use es the buriel-trensit or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? MEILITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Dinknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed BROVINCULAR DECIDENT OIL 24a. Was an autopsy IL You 24Dio 1 ☐ Yes 2 ☐ No tor: After this certific the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Certification: To 1 Yes ≥ No 4 Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation efter death. 2 Accident Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) þ 4 Homicide Hospital 24 hours e 29a. Certifier 1 🖰 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only 29b. Signature end title of certifier 29c. License number 21 2004 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ashvin Patel, M.D. 102 Paulmellion Ct. Suite 102 Waldorf, Maryland 31. Date filed (Month, Day, Year) 32. Redistrer's Signature State **JAN 23** 2004 Registra

DHMH 16 Rev 6/95

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		For	State of Ma	aryland	•			Mental Hy	giene	200	00011
		1 - State Registrar			Cer	tificate of	Death		Reg. No	2001	1 03044
-	9	1. Decedent's Name (First, Middle, La	st)					2. Date of De	aath Da	/ Year	3. Time of Death
Physic		Ruth Hale	Bu	chana	n			Januar			5:50 A M
/Medi Exami		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town,	or Location of De		1	County of Dea	
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Famouri		5. Social Security Number 6. S			st birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bi	rth	nne Aru 9. Bir	thplace (State or Foreign ountry)
Funeral Director			I□M 252F	94	Yrs.	Months Days	Hours Mi	in. (Month, Da Aug 15			Hampshire
No. All		Usual Residence of Decedent						Rug 15	, 19	O3 NEW	nampsiire
land		10a. State 10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Limits
Aary Fsh	5	New . Straff	Ford	]	Roches	ter					1√2 Yes 2 □ No
the 1	Director	Hampshire 10e. Street and Number				10f. Zip Code			10d Cit	izen of What C	ountay?
with be c	ā	136 Rochester Nec	k Road			0383	19		-	. S. A.	
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tams	nue	11. Marital Status	12. Was Decedent Armed Forces?		s. 13. V	Mas Decedent of f Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	D-	Black, Whi	
9 af 2	ΥF	1 Never Married 20 Married	1 ☐ Yes 2 ☑ 1 If Yes, Give	No		I ⊈Yes 21√2 No	Specity:			Specify: [	Thite
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re, Marylanc s 1 and 2 should be 1 f Health and Mental. Item 27 is marked o other traumatic eve	Γ,	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	g Address (Stree	t and Number or	Rural Route Numb	er, City o	r Town, State,	Zip Code)
and 2 ealth a n 27 is		Linda Buchanan/ I	)aughter		6708	Homesta	ake Drive	e, Bowie,	Mar	yland 2	20715
Hear Hear there		20a. Method of Disposition	augneer	20b. Pla	ace of Dispos	sition (Name of	. [	Date	20c. Lo	cation - City or	Town, State
or or or		14 Burial 2 ☐ Cremation 3 ☐		Pine	metery cren e Hill	natory or other pla Cemeter	v 1/2	24/2004	Dove	. New H	lampshire
Baltimore, permit. Pages 1 and Department of Heall Important: If Item 2 any injury or other.		* 4 ☐ Donation 5 ☐ Other (Specif									
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		1 2-12			10	UUU Anna	ipolis Ko	oad, Bowi	e, M	aryland	20715
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deat deat	Cig	in the past 12 months? 1 ☐ Yes 2 X No	4☐Pregnant at			Other (specify)				Month	Day Year
at the de	ys	9 Unknown	9□ Unknown								
_ 2 p g	P	Part II. Other significant conditions of	contributing to death b	ut not result	ting in the ur	iderlying cause gr	ven in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
Records, he law requires t has been signe ge 2 should be o	d by							1 🗆	Yes 2	XNo 3 □ P	robabiy 4 DUnknown
K requ	Completed							11.75		2,816.1	
Rec e law has b	효							24a. Was auto	psy	prior to	utopsy findings available completion of cause of
	5							perfo 1 ☐ Yes	rmed? 200 No	death?	2 □ No
f VITAL Reysician: The siscertificate hadrector, page	Be	25. Was case referred to medical					26. Place of D	eath (Check only o			
ysic ysic	10	examiner?	Hospital: 1 ☐ Inpatie	nt 2□E	R/Outpatien	3 DOA Ot	her: Nursing	Home 5□ Resi	dence	3 □Other (Spe	cify)
P P P		27. Manner of eath	28a. Date of Inju (Month, Da	ry 2	28b. Time of	28c. inju	ry at	28d. Describe			
on on oding the the funer	ti	1 SNatural 5 Pending 2 Accident investigation		y rear)	Injury		rk? ]Yes 2∐No				
VISIO Attendi	fice	3 ☐ Suicide 6 ☐ Could not b	289. Flace of mil	ury - At hom	ne, farm, stre	eet, factory, office		28f. Location (	Street an	d Number or Ri	ural Route Number,
DIVISION OF  I or Attending Phy after death. Director: After this in by the funeral d	Certification;	4 Homicide determined	building, etc	c. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, State	)	
DIVISION OF VITA To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier Certifying Ph	nysician: To the best	of my know	dedec death	nonurrad at the t	me data and al-	no and due to the	031105(2)	and man	stated
Hos 24 hc Fun fely	Medical	(Check only 2 Medical Examone)	niner: On the basis of	examination	on and/or inv	estigation, in my	opinion, death oc	curred at the time,	date and	place, and due	to the cause(s)
the the	Jec		and manner sta	1180.		200 1 1000	ca numbar		20d Dat	o cianad (Mant	h Day Vansi
Twit To		29b. Signature and title of certifier	////		44.0	29c. Licen				e signed (Mont	, Jay, rear;
					100)	D	3582	9	1/	17/00	T
		30. Name and address of person who	completed cause of d	eath (Item 2	23a) (Type, I	Print)	- /	o thicos	200		0
		veter widen	3 MD.	cu36	20 Ga	lat r	chland	o ETILOS	SOW	E	- 1-1
St	ate	31. Date filed (Month, Day Year) JAN 2 0	2004 32. Registra	ar's Signatu		1					
Regist	rar	JAN Z U	2004	sur.	N. A	and a					

			1 - For State of Ma	aryland / Depa <i>Cei</i>	artment of Hertificate of C		Re	g. No. 2004	03045
	Physicia	an	Decedent's Name (First, Middle, Last)     JAMES EDWARD BEALL				2. Date of Death JANUARY		3. Time of Death 7:00 AM M
>	/Medic Examin		4a. Facility Name (If not institution, give street and number) 554 OLD WESTMINSTER PIKE		4b. City, Town, or I			4c. County of Death	
	Funeral Director		215-32-5332 XXM 2□F	e (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, FEBRUAR	Year) Cou	place (State or Foreign intry) MARYLAND
	yland Iow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Man Ba-f sh	ctor	MARYLAND CARROLL	WESTM					1 Tyes 2 7
	s with the	I Dire	10e. Street and Number 554 OLD WESTMINSTER PIKE		10f. Zip Code 21157	7		g. Citizen of What Cou UNITED STA	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents if time 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic svent, the Medical Examinar must be notified at once.	by Funera	11. Marital Status  1 Never Married 2 Married 1 Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13. No NAT L GUARI	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🏋 No	spanic Origin? (Spe , Mexican, Puerto f Specify:	city Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: WHI	, etc.
21215-0036	within 72 houne.	mpleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or state)	16a. Deced (Give life.	dent's Usual Occupat kind of work done du DO NOT use retired) MEAT CUTT	uring most of workir	ng 1	6b. Kind of Business/In	
and 2	id be filed v ental Hygie ked other t ic svent, In	o Be Co	17. Father's Name (First, Middle, Last)  JOHN BEALL			18. Mother's Name LOUISE PO			<u> </u>
Maryland	nd 2 shou alth and M 27 is mar ir traumati		19a. Informant's Name/Relationship (Type, Print) ELSIE M. BEALL/WIFE					City or Town, State, Zip TMINSTER , I	
Baltimore,	ges 1 a t of Hea If item or othe		20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of matory or other place	)		0c. Location - City or To	
Ħ.	nit. Pag artment ortent: injury e.		'4 Donation 5 Other (Specify)  21. Sign ture of Funeral Service Licensee	FRIENDS (	CEMETERY  2. Name and Address	1/17/3 s of Facility	2004		G, MARYLAND
<u> </u>	Dep Per Per Per Per Per Per Per Per Per Per		Hustin R. Deut	MY.	YERS-DURBO	DRAW FUNE	RAL HOME	P.A. WEST	ILLIS ST. MINSTER, MD
	Pnysician /Medical Examiner		Sequentially list conditions b.	a consequence of):	er the mode of dying.	, such as cardiac or	Cau	ncer	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and ad for use as the buriat-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):					
P.O. Box 6	that the death certificated by the attending place detached for use as t	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	өгү Day Year
	96	by	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause giver	n in Part I.	23e. Did toba	acco use contribute to to	
Division of Vital Records,	The taw require ate has been si page 2 should b	Completed		-			24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of
Vita	Physicien: this certificaral director, I	o Be (	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatien	Othor	26. Place of Death		) ace 6 ⊟Other (Specia	4.1
on of	Attending Phy r death. ector: After this by the funeral d	H- 1	27. Manner of Death  1 Natural 5 Pending (Month, Da 2 Accident investigation	ıry 28b. Time of	f 28c. Injury Wark	_	8d. Describe hov		<i>y</i> /
Divisi	al or Attend safter death if Director: /	Certification;	3 Suicide 6 Could not be 28e. Place of Inj	iury - At home, farm, str c. (Specify)	eet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  12 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or in	h occurred at the time vestigation, in my opi	e, date and place, a inion, death occurre	nd due to the cau od at the time, dat	use(s) and manner as s te and place, and due to	itated. o the cause(s)
1	To the To the Comp	Ĕ	29b. Signature and title of certifier	^	29c. License	number	29	d. Date signed (Month,	Day, Year)
•	WIL		30. Name and address of person who completed cause of c	leath (Item 23a) (Type,	Print)	ello,	)	un 16,	2004
			31. Date filed (Month, Day, Year) 32 Registr	J 1447 par's Signature	- YOVK	rol L	-uther	ville M	10 21093
	Sta Registr		JAN 1 6 2004		frank .				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 11:30PM<sup>M</sup> 2004 RUTH K. BERRY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TALBOT EASTON 53 DAVIS LANE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2√F 90 Yrs. 157-34-1916 WASHINGTON, D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglene and an anti-titlene state and the state of the method of the than "natural", or litems 23a or 28a-1 show anti-titlene traumatic event, I'm Medical Examenaci must be conflicted at 1 Yes 2 No Director TALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 53 DAVIS LANE 21601 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ROBERT E.P. KREITER LETITIA COCKRILLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 53 DAVIS LANE, EASTON, MD 21601 WILLIAM L. SCOTT/HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or OXFORD CEMETERY 1-21-2004 OXFORD, MARYLAND \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENERIN & NEWHAM FUNERAL HOME P.A. 200 S. HARRISON ST EASTON, MD 21601 JOHN R. MERCERDA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nset and Death Immediate Cause (Final disease or condition resulting in death) month ancei Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached o 9 Unknown 9 Tunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 ☐ Yes 2 X No tibullation Division of Vital To the Hospital or Attending Physician: funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Thomicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 000 me and address of person who complete cause of death (Item 23a) (Type, Print) 31. Date filed (Month, lay, Year) 22. Registrar's Signature State JAN 2 0 2004 Registrar

			Please  1 - State Registrar	State of Maryland	l / Depa		t of H	ealth ar		tal Hygie		004	030	147
			Decedent's Name (First, Middle, Las	1)						ate of Death	Day	Year	3. Time of D	eath
	Physicia		Thomas Jess	ie Bordley						NUARY	Day	2004	0336	М
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of			4c. Cour	nty of Death		
	_Aa	•	MEMORIAL	HOSPITAL			EAS	STON				TALB	OT	
ı	Funeral Director		5. Social Security Number 6. Se		st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min. Ma	pate of Birth Month, Day, y 18,1	925	9. Birthp Cour Mary	place (State or intry) Land	Foreign
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Lo	ocation					· ·	1	10d. Inside City	Limits
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	Z8a-f	Directo	Maryland   Queen A	nnes S	<u>teven</u>	SVILL 10f. Zip				100	a. Citizen o	of What Cour	ntry?	
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0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, it is Madical Expinities must be notified at once.	by Funerai	1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 ☐ No If Yes, Give		If Yes, spe- 1 ☐ Yes		n, Mexican,  Specify:	Puerto Rica	n, etc.)		Black, White,	etc.	
3	rair, o	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 182	202 110	зрасну.			Spe	cily.	Black_	
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7	ithin ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u					_			
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	hall hall hall hall hall hall hall hall	Be		. 11						,				
<u> </u>	should be and Mental smarked o	ဥ	Alexander Bon	dley	19b. Maili	ing Address	(Street a		Sadie r or Rural Ro	ute Number,		oherd vn. State, Zip	c Code)	
<u>8</u>	d2s than trau		Marie Bordley	_		-							land 21	666
ā,	1 and Health tem 27 other tr		20a. Method of Disposition		ace of Dispo				Date			on - City or To		
Baltimore,	Pages nent of int: If its iry or o		1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State					01/26/	2004	Hur1c	ock.Ma	rvland	
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n	Dep Imp any	1	Mother St. C	RAINER		426d	le 5 lover	Stree	runera et, Ea	1 Home	aryla	and 21	601	
	;#£		23a. Part   Enter the disease, or com shock, or heart failure. List only	plications that caused the death.	. Do not en	ter the mod	de of dyin	g, such as c	ardiac or res	spiratory arres	st,		Approximate Interval Between	een
	Pnysician		Immediate Cause (Final		CeE	0	714	1 - T	Dise	ASE			Onset and De	
	/Medical		disease or condition resulting in death)	Due to (or as a consequence		100							yes	<u> </u>
	Examiner		Control William Print	TYPEI	D	1AB	212	5	m E	CLIT	15		20 40	273
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	acute ind trans	Examiner	Cause (Disease or injury that initiated events	C		200	$\mathcal{O}_{-}$							
/60,	te be executed ysician and e burial-transit	Ä	resulting in death) Last	Due to (or as a consequ	ence or):									
200	cate b	dical		. d										
X 68	ding p	/Me	IF FEMALE:	23c. If yes, outcome of pregnar	nev		-				224	Date of deliv	ian.	
ROX	death certificate be attending physical for use as the b	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3[	⊒Ectopic p □ Other (s)						Month	*	ear
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ě	The lav	m d							_	autopsy perform		death?	ompletion of ca	use of
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of Vital Records,	Physician: r this certific ral director,	0 8	examiner?	Hospital: 1 I Impatient 2 1	ER/Outpatie	ent 3 D	OA Oth	ar:		5 Resider		Other (Speci	ify)	
o	a Phy ar this aral d	I	27. Manner of Death	28a. Date of Injury	28b. Time o		28c. Injur Wor	y at		Describe how			<i>,</i> ,	
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ō	rs after al Dir	Certification;								-				
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical (	29a. Certifier 1 Certifying Pt	nysician: To the best of my knowniner: On the basis of examinat	wledge, dea ion and/or ii	th occurred	at the tir	πe, date and pinion, deatl	d place, and h occurred a	due to the car t the time, da	use(s) and te and plac	manner as s	stated. to the cause(s)	
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			30. Name and address of person who				C t.	4. 17		(n.ee7 -		601		
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THOMAS BORDLEY

			Co.	State of Maryland / Dep	artment of Health and I	Mental Hygi	ene 2001. 0201.0
		1	- State Amended E	5. per fh 1-2104 CE	ertificate of Death 🕜	HD AS RO	g. No. 2004 00040
*	- p		1. Decedent's Name (First, Middle, Last,			2. Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic	al -	Irene Bilbroug			January	
X	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death
			Caroline Nursing F		Denton  If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign
4	Funeral Director		215-36-0438	M 2∏F 93 Yrs.	Months Days Hours Min.	(Month, Day, Oct. 4,1	Year) Country)
To the second	No. o page to		Usual Residence of Decedent			0000 1,12	
	rylan how		10a. State 10b. County	10c. City, Town or I	Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-1-	Director	Maryland Carolin	ne Greensb		10	
	vith th	Die	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?
	8 23e	by Funerai	26960 Bilbrough Ro	oad 12. Was Decedent Ever in U.S. 13	21639 Was Decedent of Hispanic Origin? (S	Specify Yes or No-	U.S.A.  14. Race - American Indian,
	ter de	Fu	1 ☑ Never Married 2 ☐ Married	1 ☐ Yes 2 🛣 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.
920	urs al		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: white
215-0036	72 hours after death with the Maryland natural, or Items 23e or 28e-f show dical Examinat for collified at	Completed	15. Decedent's Edu (Specify only highest grad	le completed) (Gis	edent's Usual Occupation we kind of work done during most of wo	rking 1	6b. Kind of Business/Industry
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121	Hygie Hygie ther t	e Co	11. Father's Name (First, Middle, Last)	<u> </u>	spector 18. Mother's Na	me (First, Middle, M	Apparel  (aiden Sumame)
and	d be d antail	To Be	John Alwine Bilbro	nugh	Nellie	Bishop	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heatit and Mental Hygiene it Heatit and Mental Hygiene I thow 127 is marked other than "netural", or Items 23s or 28s-f show other traumatic event, I'm Medical Examinar must be incliffed at	F	19a. Informant's Name/Relationship (T)		iling Address (Street and Number or Ri	<del>_</del>	City or Town, State, Zip Code)
2	and 2 ealth a n 27 is		Della Mae Bilbrous	gh sister-in-law 2	6960 Bilbrough Rd	Greens	boro, MD 21639
altimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Place of Dis	position (Name of rematory or other place)	Date 2	Oc. Location - City or Town, State
<u>ii</u>	Pages nent of ant: If It ury or o		'4 Donation 5 Other (Specify,	Greensbo			reensboro,Maryland
Salt	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Licens	iee I	22. Name and Address of Facility Fleegle and Helfen	bein Fune	ral Home PA
8	907 e a		Megan (F	lications that caused the death. Do not e	20 Box 160 Greens	boro, MD	21639 st. Approximate
			shock, or heart failure. List only o	ne cause on each line.			Oncet and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Acute Gast	rointestinal	bleed	2 Iday
	Examiner			Due to (or as a consequence of):			•
	Sep. 4	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):			
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x 68	death certificate e attending phys d for use as the	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery
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of	Phys this al di	2	1 Yes 22No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpat  28a. Date of Injury 28b. Time	ient 3 DOA 4 Privirsing	Home 5 Reside	nce 6 Other (Specify) w injury occurred
uo	ding l h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Day Year) Injury			,,
Division of Vital Records,	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,	street, factory, office	28f. Location (Str City or Town	reet and Number or Rural Route Number,
Ö	al or a after it Dire	Certification;	4 Homicide	building, etc. (Specify)		City of Town	
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	ledical (	29a. Certifier (Check only 2 Madical Exam	ysician: To the best of my knowledge, de niner: On the basis of examination and/or	eath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the ca curred at the time, da	ause(s) and manner as stated.  ate and place, and due to the cause(s)
	the hin 24 the f	Medi	one)	and manner stated.	29c. License number	29	9d. Date signed (Month, Day, Year)
	or To Co		29b. Signature and title of certifier	Sesson MY			
			30. Name and address of person who	cempleted cause of death (Item 23a) (Typ	pe, Print)		
			James Sid	es 920 /hr	Ket St De	itar	-16-04 MD 21629
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature			7
	Regist	rar	1AN 0 A 200	a live of the state	all a		

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 () () [ State Registrar Amend item#8perFHG828 2/21/04 EW Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 4:40 a.m. 24, 2004 O'Bryan January Baxter /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Lexington Park St. Mary's 45582 Camelot Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day Year)
ALG 25 1905 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 ₽ F 98 Illinois Director 214-60-3012 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County or 28a-f show the Mudical Examiner must be notified at 1 ☐ Yes 2 No Director St. Mary's Maryland <u>Lexington Park</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number \*natural', or Iteme 23e 20653 United States 45582 Camelot Court death Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 1 No Yes, Give filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "na any injury or other traumatic event, It a Muster 2006. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Susan Steffans Sherman O'Bryan ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11345 Cherry Point Street, Paris, IL 61944 Philip O'Bryan / Great Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2-13-2004 Arlington, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature: Edward N. Brinsfield, Je M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Lo not enter the mode of dying, such as or rdiac or respiratory arrest, shock, or heart failure. List only one cause me ach line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical insequerice of): to (or as a Examiner 112 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transil that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year detached for 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 22 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No in by the funeral director. 26. Place of Death Check only she Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA 2 ER/Outpatient Medical Certification: To 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred fnjury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicíde filled within 24 hours a
To the Funeral C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 0000 506 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon Berube, M.D., 28170 Old Village Road, Mechanicsville, Maryland 20659 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State IAN 28 Registrar

			1 - For State Registrar	tate of Maryland		artment of H			jiene 20	04	030	50
*			Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of De	ath
	Physici		John Ernest	Bassford				January			10:00	Рм
	/Medic Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of Death		4c. County	of Deeth		
			St. Mary's Nursing	Center		Leona	rdtown		St.	Mar	y¹s	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day			lace (State or F	oreign
ı.	Director		212-24-8401	2□ F	75 Yrs.	Working Days	Tiodis IVIII.	June 21,			ryland	
	P _		Usual Residence of Decedent	10a Cib	Taum or La						0d. Inside City I	Limits
	ahow	_	10a. State 10b. County	100. 01()	, Town or Lo	Cation					1 Tes 2	
	Ba-f	cto	Maryland St. Mary's	Ho	011ywo				0.000			
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	within 72 hours after deeth with the Maryland ene. than "natural", or items 23a or 28a-f ehow ha Medical Examinat must be notified at	Funeral Director	24011 Mervell Dean H			2063			United			
	tems	nue	11. Walkar Olatos	Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecity Yes or No- Rican, etc.)		c, While,	en Indian, elc.	
36	or i	by Fi	1 ☐ Never Married 2 📆 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give	,	1 ☐ Yes 2 🛣 No	Specify:		Specify:	W	ite	
Ö	hour ural	p p	15. Decedent's Educat	Year or Dates:	16a Decer	dent's Usual Occup	ation	· · · · · · · · · · · · · · · · · · ·	16b. Kind of Bu	siness/In	dustry	
2	"na "na	Completed	(Specify only highest grade of		(Give	kind of work done of	during most of work	ing	100. 14110 01 04	31110004111	ouoti y	
2	within	m	Elementary/Secondary (0-12)	College (1-4or 5+)		Carpenter			U.S. G	01701	nment	
2 2	Hygin ther		17. Father's Name (First, Middle, Last)			bar penreer	18. Mother's Name	e (First, Middle,			mich	
an	d be	o Be	William Franc	is Bassford	Sr.		Anna Ru	ıth Nor	ris			
2	iges 1 and 2 should be filed within 72 hours after deeth with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f ehow or other traumatic event, the Medical Examinat must be notified at	5	19a. Informant's Name/Relationship (Type,			g Address (Street				State, Zip	Code)	
<u>8</u>	d 2 s th ar 27 is trau		Mary Louise Bassford		1	Mervell						
ē,	1 an Heal tem		20a. Method of Disposition	20b. P	ace of Dispo	sition (Name of		Date	20c. Location - I			
<u></u>	Pages nent of int: If It iry or o		1 ⊠Burial 2 □ Cremation 3 □ Rem  4 □ Donation 5 □ Other (Specify)	oval from State	•	natory`or other plac Cemetery		05/2004	Hollyw	hoo	Marula	nd
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health at Important: If Item 27 is any injury or other trau		21. Signature of Funeral Service Licensee	1		. Name and Addres		372004	HOLLYW	oou,	Maryra	iiu
Ba	permit. Departn Imports any inju		La Vous	H. L.	/	Mattingley P.O. Box 2	-Gardiner F	uneral Ho	ne, P.A.			
6			23a. Part 1. Enler the disease, or complication	ions that caused the seath							Approximate	
n			shock, or heart failure. List only one of Immediate Cause (Final	cause on each line.	5 7	1	12 00				Onset an VI ea	ən ath
	Physician /Medical		disease or condition resulting in death)	KELD	Nach	waya	Sur 12		1		WK	-
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		<u></u>	Sequentially list conditions, b	Due to (or as a consequ	rence of).	O'AV MU	u E Mi	micery	Gro En	42	9000	-
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					/			0	
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ě	has ge 2	П						autop: perfor	med? p	rior to cor eath?	inpletion of caus	se of
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ב	ding l h. After funer	ion	1-2Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No		,			
S	Attending Physician: r death. ector: After this certification the funeral director.	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm str			28f. Location (S	reet and Number	r or Rura	l Route Number	r.
<u>&gt;</u>	lor A after Direction by	it.	4 Homicide determined	building, etc. (Specify	)			City or Tow	n, State)			
_	To the Hospitel or Attending Physician: The lawithin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physic	an: To the best of my know	wledge, death	occurred at the tin	ne, date and place.	and due to the c	ause(s) and mar	ner as s	ated.	
	Hos 24 hc Fun etely	edical	(Check only 2 Medical Examiner one)	: On the basis of examinat	ion and/or inv	vestigation, in my o	pinion, death occur	red at the time, o	ate and place, a	nd due to	the cause(s)	
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	1		29c. Licens	e number	2	9d. Date signed	(Month,	Day, Year)	
j	⊢ 3 F ŏ		· Inil	ball ment	4.1	1	06419		1-2	- ^	4	
			30. Name and address of person who comp	leted cause of death (from	23a) (Tuch	Print)	(   /		1 3		Į.	
			James Patrick Jarb	/			MJ on	626				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signar		Hollywood	A DIU ZU	030				
	Registr		JAN 0 2 20	04	13 6	made						

		For State Registrar	State of	Maryland				ealth a Death			jiene ,	2001	0305
		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month		Year	3. Time of Death
Physic /Med		Mary Ca	therine	Babcoc	k					January	7 13,	2004	4:05 PM
Exami		4a. Facility Name (If not institution, give	e street and num	iber)		4b. City,	Town, or	Location	of Death		4c. C	ounty of Dear	th
		Solomons Nursin	g Center	<b>:</b>		1	Solom	ions				Calver	t
Funera Director		3/1-34-0620	ex □M 2ŽTF	7. Age (In yrs. I		If Unde Months	Days	If Under Hours	Min. A	8. Date of Birth (Month, Day ugust 2	8,19	9. Bin Ca	thplace (State or Foreign auntry) anada
pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
taryla sho	ō	Maryland Calve	rt	Т	Lusby								1 ☐ Yes 2X No
the A	ect	10e. Street and Number			doby	10f. Zir	Code				Oa. Citize	on of What Co	ountry?
with with	<u> </u>	12046 Settlers	Trail				2065	57			-	ada	,
leath	era	11. Marital Status	12. Was Deced	dent Ever in U.S	S. 13.	Was Dece			gin? (Spec	cify Yes or No-		l. Race - Ame	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it a Moulcal Expedition 1 and item published.	by Funeral Directo	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Ford  1  Yes  ff Yes, Give  Year or Da	2 🔯 No 3		If Yes, spe 1 ☐ Yes		n, Mexicar Specity:		lican, etc.)	s	Bfack, Whit	e, etc. Vhite
ind if jeared within 72 hours at the and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Modical Extern.	ed	15. Decedent's E			16a. Dece	dent's Usu	al Occupa	ition			16b. Kind	of Business	/Industry
in 72	Completed	(Specify only highest gra	de completed)	4555.\	(Give life.	kind of wo	ork done d ise retired,	<i>luring</i> mos )	t of workin	9			•
iene.	E	Efementary/Secondary (0-12)	Colfege (1-	401 5+)	Lec	ture	Agen	nt			Comm	unicat	ions
12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, its Mental Hygiene.	BeC	17. Father's Name (First, Middle, Last	)	,				18. Mothe	r's Name	(First, Middle,	Maiden S	итате)	
id be ental ked	To B	Edward Murary G	arrity					C1.	ara	(Unknow	m)		
shour nd M	-	19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ng Address	s (Street a	ind Numbe	or Or Rural	Route Number	, City or	Town, State, 2	Zip Code)
nd 2 aith a 27 is		August Joseph Ste	fkovich	/ Son	P.C	. Box	x 861	Lu	sby,	MD 206	557		
item 27 is	1-1	20a. Method of Disposition		1 00	lace of Dispo	sition (Na	me of	a)	Janu	iarv	20c. Loca	ation - City or	Town, State
age ent o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special		tate	tropoli					-	Alexa	ındria.	Virginia
permit. Pages 1 ar Department of Hea Important: If item any injury or otha once.		21. Signature of Funeral Service Lice	nsee	· · · · · · · · · · · · · · · · · · ·	) 22	Name a	nd Addres	s of Facility - Ga	rdine Leon	r Funer	al H	ome P	, A.
COLUMN TO SERVICE		23a. Part1. Enter the disease or com	plications that ca	used the death	Carrier Strategie							2003	Approximate
		shock, or heart failure. List only	offe cause on ea	ich line.		*	,			, , .	,		Interval Between Onset and Death
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Examiner		1	Due to (d	or as a consequ	uence of):								
		Sequentially list conditions,	b. Dua to (c	or as a consequ	ianna oth								
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	30010 (0	n as a consequ	01,000								
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attendin for use	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bit	rth 2 ☐ Fetal	death 3	Ectopic p					23	Month	Day Year
the de	ysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9 Unkno		aui J	1 Other (a)	Dociny)						
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ng P fter t	on:	27. Manper of Death  → Natural 5 Pending	28a. Date of (Month)	f Injury n, <i>Day Year)</i>	28b. Time o Injury		28c. Injury Work			8d. Describe ho	ow injury	occurred	
Attending r death.	cati	2 Accident investigation 3 Suicide 6 Could not be				М		/es 2 □					
at or Attending after death. I Director: After d in by the fune	Certification:	4 Homicide determined	280. Place	of Injury - At ho g, etc. (Specify	me, farm, sti	eet, factor	y, office		28	Bf. Location (SI City or Town		Number or Ru	iral Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example		sis of examinat									
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		30. Name and addlers of person who	completed cause	of death /Item	23a) (Type	Print)		,	V			1 1	
		Sylvia Batong M		345 H.G			Rd.	Lusb	y, MD	20657	,		
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Regis		IAN 15	2004		20 1	P 11							

ORIGINAL

			1 - For State Registrar	State of Mary		artment of H			iene g. No. 20	04 (	3052
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Deat Month	h Day	Yeer	Time of Death
>	/Medio		CHARLES  4a. Facility Name (If not institution, give	street and number)	CANNETTI	4b. City, Town, o	or Location of De		1 2004 4c. County o		:30
			NATIONAL NAVAL 1  5. Social Security Number 6. Se		ER yrs. last birthday)	BETH	ESDA	Irs 9 Date of Righ		TGOMER	
	Funeral Director		100-20-2545	<b>X</b> M 2□F	74 Yrs.	Months Days		Irs. 8. Date of Birth (Month, Day, Feb 26,		Country) New Yor	(State or Foreign
	Maryland -I show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland St. Mary		c. City, Town or Lo	ocation					nside City Limits
	or 28a	Director	10e. Street and Number	5 110	ark Harr	10f. Zip Code		10	g. Citizen of Wh	nat Country?	
	ss 23a	eral	18315 Point Looko	ut Road  12. Was Decedent Ever	in II G	20667			JSA		4
920	urs after d al', or item	by Funeral	11. Marital Status  1 ■ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	Armed Forces? 1 XYes 2 ☐ No	1951-	was Decedent of F If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	(Specify Yes or No- erto Rican, etc.)		- American Inc , White, etc. White	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other treumatic event, its Medical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of v	vorking	6b. Kind of Busi		
	filed w Hygier other th		12th 17. Father's Name (First, Middle, Last)		Ar	tist	18 Mother's N	lame (First, Middle, N	Self Em	-	
Maryland	Mental I Merical I mrked o	To Be	Charles Cannetti					a Salvioli			
Man	12 should and Men is marke reumatic		19a. Informant's Name/Relationship (Ty					Rural Route Number,	•		
altimore, r	Pages 1 and 3 nent of Health int: If Item 27 iry or other tru		Joseph Cannetti / 20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ F	Removal from State	b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	ce)		Oc. Location - C	ity or Town, S	State
Baltin	permit. Pages Department of Important: If is any injury or o		21. Signature of Fineral Service kitens	i .		. Name and Addre	ss of Facility	24-2004 <sup>Cl</sup> Brinsfield Load, Leona	Funeral	Home,	
	Haulet.	-	23a. Part1. Enter the disease, or compleshock, or heart failure. List only	ications that caused the cause on each line.						Appr	oximate val Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	SEPSIS						Onse	et and Death
	Examiner			Due to (or as a cor	sequence of):						
	ed isit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olegate of Injury)	Due to (or as a con	sequence of):						
8/60,	cate be executed physician and the burial-transit	dical Examine	that initiated events resulting in death) Last	Due to (or as a con	sequence of):						
U. Box 68	ath certifi attending por use as	hysician/Medi	in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ If 4 ☐ Pregnant at time 9 ☐ Unknown	etel death 3	Ectopic pregnancy			23d. Date of Month		Year
ř	res that the de igned by the a be detached to	by Phy	9 ☐ Unknown  Part II. Other significant conditions con		resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	icco use contribe	ute to the cau	se of death?
Hecords	w requires been sign should be							1 🗌 Yes	2 No 3	Probably	4X Unknown
	The law ate has b page 2 st	Completed						24a. Was an autopsy perform	priq ed? dea	ire autopsy fin or to completio ath? ] Yes 2 2 N	
VII		o Be	25. Was case referred to medical examiner?  1 Yes 2 XNo	lospital:	2 ☐ ER/Outpatien	3 DOA Othe		eath (Check only one	100000000000000000000000000000000000000	1531.	
lon or	ling After une	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea.		28c. Injury Work		Home 5 Residen 28d. Describe how			
DIVISION	spitel or Attendii ours after death. ere! Director: A filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, streecify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number ( State)	or Rural Route	e Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the t	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	sician: To the best of my ner: On the basis of exan and manner stated.	knowledge, death nination and/or inv	occurred at the timestigation, in my op	e, date and plac pinion, death occ	ce, and due to the cau curred at the time, dat	ise(s) and manne e and place, and	er as stated. I due to the ca	ause(s)
	To To	Σ	29b. Signature and title of certifier	J 1	0	29c. License		290	d. Date signed (A	_	
1	1		30. Name and address of person who co	mpleted cause of death (	7.7		79 (NY) NA	TIONAL NAV		CAL CEN	1
	/		SAM W. GAO, LT MO	C USNR				THESDA MD			AT DIV
	Star Registra		31. Date filed (Month, Day, Year)	32. Register's Si 2004		Soule					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:25 Рм January 21. 2004 Joseph Copsey Philip /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner St. Mary's 22680 Cedar Lane Court, Apartment 1401 Leonardtown tf Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 7. Age (In yrs, last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 💢 M 2 🗆 F July 1, 1929 Maryland Director 213-26-7955 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location rthen "natural", or Iteme 23a or 28a-f show the Medical Examiner must be motified at 1XXYes 2 □ No Leonardtown Maryland St. Mary's Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22680 Cedar Lane Court, Apartment 1401 20650 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 7 - then Elementary/Secondary (0-12) Coltege (1-4or 5+) Clothing Laborer 12 should be filed w h and Mental Hygier 7 le marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daisy Mary Burch Armistead Arthur Copsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Ie m eny injury or other traum once. Elizabeth Cecelia Borgo/Sister 38 Madburry Road, Apartment 307, Durham, New Hampshire 03824 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 26, 1XXBurial 2 Cremation 3 Removal from State Morganza, Maryland Joseph's Cemetery 4 □ Donation 5 □ Other (Specify) 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility michael Klira Mattingley-Gardiner Funeral Home, P.A. Hendener P.O. Box 270, Leonardtown, Maryland 20650 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) una Cancer **Physician** /Medical Heart Failure Rend Bisease Due to (or as a consequence of): **Examiner** Congestive cause thany list our difficus, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a conseque to of): the attending physician by Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year õ Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed bluods 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed per cholesterolemic 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate 2 No 1 Yes the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 24 hours after of Funeral Direct 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely within 2 To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 1-23-04 D55027 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33767 Market Drive, Charlotte Hall, Maryland 20622 Dr. Manjo Panwala, 2004 Registrar's Signature State Marche !

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

ate of Maryland / Department of Health and N	Mental Hygiene	1
Certificate of Death	20	Į

			1 - For State Registrar	oraro or mar	Cei	rtificate of	Death	Worker 119	Reg. No.	104	0305
ı	Physici	3 <b>n</b>	Decedent's Name (First, Middle, Last	)				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Arthur Wils	son Co	rson, Jr.			JANUAR		2004	10:25 p M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dear	th		y of Death	
			St. Mary's Hosp:				eonardto			t. Ma	
	Funeral		5. Social Security Number 6. Se.		In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	iy, Year)	9. Birthp Cour	place (State or Foreign htry)
×	Director		Usual Residence of Decedent	7 2 7 5	) 115.			Aug. 12,	, 1928	Penr	sylvania
	and and		10a. State 10b. County	1	Oc. City, Town or Lo	cation	<del></del>			1	0d. Inside City Limits
	Mary	ō	Marvland St. Ma	!		Lorrin	atan Dan	.1-			1 ☐ Yes 2 █ No
	the 28a	Directo	Maryland St. Ma 10e. Street and Number	ary s		10f. Zip Code	gton Par	K	10g. Citizen of	What Cour	ntry?
	with 3a or		20440 Poplar Ridg	ro Pond			0653		United		,
	hours after death with the Maryland tural', or Items 23a or 28a-f show al Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13. \	Was Decedent of H f Yes, specify Cuba		Specify Yes or No		ce - Americ	an Indian.
0	ifter of	Ē	1 Never Married 2 Married	Armed Forces? 1   Yes 2   No	1945-			to Rican, etc.)		ck, White,	etc.
3	ours a	by	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:	1971	I ☐ Yes 2 █ No	Specity:		Specif	y: Whi	Lte
212-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id othar than "natural", or Items 23s or 28s-f show othar than "natural", or Items 23s or 28s-f show event, Ita Medical Examination in the Med	Completed	15. Decedent's Edu (Specify only highest grad			lent's Usual Occupi kind of work done of		rking	16b. Kind of B	usiness/Ind	dustry
N	within ene. than	n ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	iife. L	DO NOT use retired	i)	ikiig			
7	fited wi Hygien other th	ပ္ပ	12		Flig	tht Engin	eer		U.S. N	lavy	
yiand	tal Hydrath of oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Sumar	ne)	
<u>8</u>	ould be Mental Parked Patic ev	၉	Arthur Wilson Co				Eva Gu				
Mar	2 sh and is m	0 9	19a. Informant's Name/Relationship (Ty	• • •		g Address (Street a					
e,	and ealth m 27 her ti		Eva J. Corson / 1			Far Cry					
5	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked sny injury or other traumatic ev ance.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F	lemoval from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other plac	θ)	Date	20c. Location	- City or To	wn, State
pairimor	Pag men tant: jury		`4 ☐ Donation 5 ☐ Other (Specify)		Evergreer			-2004 1			
ğ	epart epart npor ny in		21. Signature of Funeral Service Cicers	**/		. Name and Addres					
_	<b>40</b> = # d	) I	Edward N. Brinsfie				<del></del>			, MD	20650-0279
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the ne cause on each line.	e death. Do not ente	er the mode of dying	g, such as cardia	c or respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pnei	monio	9					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):		_				
	LAGIIIIIEI		Sequentially list conditions	du	ig co	unier	5	tage	III B		
	D #	ine	Segmentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	ons Wuence of):			U,			
	and trans	Examiner	that initiated events resulting in death) Last	b							
Š	oe ex			Due to (or as a c	onsequence of):					-4	
00/00	certificate be executed iding physician and ise as the burial-transit	Medicai		1							
*	D a		IF FEMALE:		- 2020		21112				
Ö	death c	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 [	Fetal death 3	Ectopic pregnancy			1	te of delive	ry Day Year
5	the a	hysician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e of death 5	Other (specify)			1410		ouy real
	The law requires that the death ce ate has been signed by the attendi bage 2 should be detached for use	Q.	Part II. Other significant conditions cor	stribution to death but o	ot reculting in the up	dorhina souce au	on in Cort I	22a Did to	phonon uno nont	ribusa sa sh	e cause of death?
Ų	ires t signe	by	Tak ii. Othor significant containons con	ichbatting to caatii but i	or resuming in the di	idenying cause give	erinir atrii.				Δ.
cords	w require been si should I	Completed							res 2□No	3 L F1002	ably 4 Unknown
บ	alaw has b	npie						24a. Was autop	sy	prior to com	sy findings available appletion of cause of
=	The Late has	So							rmed? 2XNo	death? I 🗌 Yes	2 🗆 No
A II d	Physician: The law r this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?		-			ith (Check only o			
5	hysi this c	2	TU TOS ZIANO	ospital: 1 X Inpatient	2 ER/Outpatient	3□ DOA Othe	4 Nursing H	lome 5 Resid	lence 6 □Oth	er (Specity	)
=	ng P	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yo	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe h			
NISIO	eath.	ertification;	2 Accident investigation				res 2□No				
$\geq$	or At fter d irect n by	Ē	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, stre S <i>pecify)</i>	et, factory, office		28f. Location (S City or Tow	Street and Numb m. State)	er or Rural	Route Number,
נ	urs al	O		222							
	Hosp 4 hou Fune Bly fil	edicai	(Check only 2   Medical Examin	cician: To the best of n	amination and/or inv	occurred at the tim	e, date and place inion, death occu	, and due to the o	cause(s) and ma	nner as sta	ated. the cause(s)
	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Med	0.1197	and manner stated							
	7 × 0 0		29b. Signature and title of certifier	1		29c. License			29d. Date signed	. '	
	W.E		Tona	n			7066	>	1 - 7	- 4	
16	7	11 1	30. Name and address of person who co	mpleted cause of deat	n (Item 23a) (Type, F	Print)					

Registrar DHMH 17 Rev 1/2001

State

ARTHUR WILSON CORSON

20650

AVANI D SHAH PO BX 404 MEDICAL ARTS BLDG LEONARDTOWN MD

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 21, 2004 6:55AM Arlie Conner January James /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Denton Caroline Nursing Home, Inc. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** Days Hours **№** M 2□ F Yrs Director 213-14-7568 February 21, 1922 Maryland 81 Usuel Residence of Decedent 10a Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov Director 1 ☐ Yes 2 ☐ No <u>Maryland</u> Croline Denton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Pegas 1 end 2 should be filed within 72 hours after deeth with ŏ Itame 23a 21629 United States 219 South Third Street Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 1942-HYes, Give Year or Dates: 1945 Baltimore, Maryland 21215-0020 5 1□ Yes 2□ No Specify 3 ☐ Widowed 4 ☐ Divorced "natural". Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 11 HS Grad. Supervisor 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of Elsie Edwards Arlie James Conner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Depertment of Heelth e important: if itam 27 is any injury or other trau 219 South Third Street, Denton, Maryland 21629 Mary L. Conner Wife 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State 1/24/04 Denton, Maryland Denton Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Be Completed by Physician/Medical Examiner the attanding physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2LVNU 1 ☐ Yes 2 No 1L Yes certificata 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Certification: To 1 Yes 2 No 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this eral Diractor: After this filled in by the funerel 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No aftar death. 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

within 24 hours a

To the Funeral D

completely filled i

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 2

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

2004

920 Marke

32. Registrer's Signature

i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Denton MQ 21629

	. For	State of Ma		rtment of Health a	nd Mental Hy	giene	00056
	1 - State Registrar		Cer	tificate of Death		Reg. No. 4	<u> </u>
Physician	Decedent's Name (First, Middle RONALD	SEWELL	CUMMING	3	2. Date of De Month	Day Year	3. Time of Death  2235 M
/Medical	4a. Facility Name (If not institution,		00111121101	4b. City, Town, or Location of	Death	4c. County of Deel	
Examiner	University	Speciality	Hospital	Baltimere		Baltim	
Funeral	0.000		(In yrs. hast birthday)	If Under 1 Year If Under 2 Months Days Hours	Min. (Month, Da	th 9. Bird	thplace (State or Foreign buntry)
Director	214-36-5728 Usual Residence of Decedent	M.H. 201	66 Yrs.		0ct.3	0,1937 Ba	ltimore
yland	10a. State 10b. County		10c. City, Town or Lo				10d. Inside City Limits
B Mar ta-f st	MD Tal	bot		Easto	)n		1 Yes 2 □ No
Local with the Marylan vurs after death with the Marylan al., or Items 23e or 28e f show Exercit at must be rediffed at by Funeral Director	10e. Street and Number 201 Federal	Street. A	nt. 38	10f. Zip Code 21601		10g. Citizen of What Co United St	•
fier death v	11. Marital Status	12. Was Decedent B		Vas Decedent of Hispanic Orig Yes, specify Cuban, Mexican,			erican Indian,
or Item		Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give	lo	Yes, specify Cuban, Mexican,	Puerto Hican, etc.)		hite
ural', o		Year or Dates:	37-39	ent's Usual Occupation		16b. Kind of Business	
in 72 lin	15. Decedant (Specify only highes	t grade completed)  College (1-4or 5	(Give	kind of work done during most DO NOT use retired)	of working		
ed within 72 hor ygiene. Tr. the Medical t, the Medical	Elementary/Secondary (0-12)	College (1-4or 5	Pai	nter		Residen	tial ————
be filed within 72 hours after death with the Maryland hall tyglene. Id other than "natural", or Items 23e or 28e-f show event, the Medical Ever it ar must be notified at the Completed by Funeral Director.	17. Father's Name (First, Middle,		nas		's Name (First, Middle ive Olivi		
Vacing the properties of the p	19a. Informant's Name/Relations		19b. Mailir	g Address (Street and Number	r or Rural Route Numb	er, City or Town, State,	Zip Code)
od 2 st ith and 27 is r traun	Ronnie L. Ci	immings/So	n 4768	Poplar Necl	Rd., Pr	eston, MD	21655
s 1 and s 1 and if Health item 27 other tu	20a. Method of Disposition	- TD	20b. Place of Dispo	sition (Name of natory or other place) Cream.Ctr	Date 0.1 / 1.2 / 0.4	20c. Location - City or	2.77
Pages ment of I	1 ☐ Burial 2 🛣 Cremation  4 ☐ Donation 5 ☐ Other (S					Cambridg	
permit. Pages 1 and 2 should permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.	21. Signature of Funeral Service	Licensee M. C	vale_F	Name and Address of Facility ederalsburg	Frampton MD 2163	Funeral	Hm., P.A.
	23a. 111. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death. Do not ent	er the mode of dying, such as	cardiac or respiratory a	irrest,	Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition	_ a.	aneumon	ia			15 days
/Medical Examiner	resulting in death)	Due to (or a	a consequence of):	Vascular	dinen	0.0	>2 110000
	Sequentially list conditions, if any, leading to immediate	b. Due to or as	a consequence of):	- Mascarda	una		Charles
executed executed in and interest	cause. Enter Underlying Cause (Disease or injury that initiated events	С					
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ilicate be e g physiciar as the burit		d					
box o8/ou, death certificate be executed death certificate be executed death certificate be executed d for use as the burial-transit	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy		23d. Date of de	
at the death certion of the death certion of the attending letached for use a brussing and the death of the d	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Other (specify)		Month	Day Year
wequires that the debeen signed by the should be detached	9 Unknown Part II. Other significant condition	ons contributing to death h	ut not resulting in the u	nderlying cause given in Part I.	23e. Did	tobacco use contribute !	to the cause of death?
d be d	3		······································		10	Yes 2□No 3☑P	Probably 4 Unknown
The law require ents that the law requirements the law					24a. Was		utopsy findings available completion of cause of
					auto perf 1 ☐ Yes	ormed3   death?	
ysician: The ysician: The is certificate director, pag	25. Was case referred to medica				of Death (Check only	one)	
hys his	1 ☐ Yes 2 ☐ No	Hospital:	1			idence 6 Other (Spender)	ecify)
On O	27. Manner of Death  1. Natural 5 Pendir	28a. Date of Inju (Month, Da	y Year) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐		Tiow injury occurred	
DIVISION I or Attending after death. Director: Afte	2 Accident investi	not be 28e. Place of In	jury - At home, farm, st	reet, factory, office		(Street and Number or Fown, State)	Rural Route Number,
DIVISION C  Ital or Attending P Its after death. Fol Director: After t led in by the funera	4 Homicide	building, 6	tc. (Specify)				
	29a Certifier 1 Certify	ng Physicien: To the best Exeminer: On the basis of and manner st	of examination and/or in	h occurred at the time, date an vestigation, in my opinion, dea	d place, and due to the th occurred at the time	e cause(s) and manner a , date and place, and du	as stated. ue to the cause(s)
To th within To th compl	29b. Signature and title of certifie		Medica	29c. License number	00	29d. Date signed (Mor	
	1 XXV	of lee	Directo	v D563	199	Junuan	12,2004
	30. Name and address of person  Jeanette T			S. Charles	St. Balt	imore, MD	21230
State	as Divisited (Manath Day Voca	32 Regist	rar's Signature				
Registra		2004	as St. Af				

State of Maryland / Department of Health and Mental Hygiene 2004

03057 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician EMMA** GRACE YOUNG CLENDANIEL JANUARY 16. 2004 08:45 AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner RUXTON HEALTH OF DENTON DENTON CAROLINE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. lest birthdey) Funeral Birthplece (State or Foreign Country) Days 1□M 2X F Yrs Director 217-82-2414 89 01-04-1915 MARYLAND Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Marylend nent of Haalth end Mentel Hygiene. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 ☐ Yes 2 X No MARYLAND CAROLINE MARYDEL 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 18695 Funeral ZION ROAD 21649 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. i Haalth end Mentel Hyglene. Item 27 is marked other than "natural", or flem other traumatic event, the Medical Examiner. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER RESIDENCE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JESSE Α. YOUNG LILL THOMAS 19a. Informant's Name/Relationship (Type, Print) (HUSBAND) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i GEORGE S. CLENDANIEL JR. 18695 ZION ROAD, MARYDEL, MARYLAND 21649 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) injury BARRATTS CHAPEL CEMTERY 01-21-04 FREDERICA, DELAWARE 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility TRADER FUNERAL HOME INC. 12 LOTUS ST., DOVER, DELAWARE 19901 nemos 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Cerebro Vascular accidents seek Examiner Physician/Medical Examiner ata has bean signed by tha attanding physicien and paga 2 should be datached for usa as the burial-transit Hospital or Attanding Physician: The law raquiras that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 20030 þ Completed 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No edical Certification: To erai Director: After this filled in by the funerel d 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral D completaly filled Exitiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10047534 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) WAKIS ZAKI MD 920 MARKET ST., DENTON, MARYLAND 21629 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar JAN 2 0 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EĽ<sup>Da</sup> **Physician** January 2004 Agnes Julia Cape 6:10 a<sup>M</sup> /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ctr Examiner Carroll Lutheran Village Health Care Westminster Carrol1 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 Days Hours **Director** 213-20-8316 20 1922 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at MD Carroll Westminster 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 St. Luke Circle 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Peges 1 end 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ Specify: 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Jackson Tracey Agnes Theresa Cassily 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Julia Wojcik/daughter 6240 Waterloo Drive Easton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1/16 2004 permit. Peges Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial Gardens Finksburg, MD \*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Pritts funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part1. Ent-T the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not ente Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physicien should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknow/ ontributing to death but pesulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probebly 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s certificate has 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this Manner of Death
Natural
Control 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signarde and title of certifie WS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTVINOSTE ER 32. Registrar's Signature Date filed (Month, Day, Year) State **JAN 15** 2004 Registrar Breek

Susan T. Coffey 04-00429 AKG

00	429		For State Registrar	State	of Marylan		artmen rtificat			and M		giene Reg. No.		4 03	059
	- 38.		Decedent's Name (First, Middle,								2. Date of De	ath Day	Yea	3. Time o	f Death
П	Physici /Medic		Susan Theresa	a Coff	ey						Janua:	ry 1	5, 2004	5:1	.5 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	give street and no	ımber)		4b. City,	Town, or	Location of	of Death		4c.	County of De		
Se			3554 Edgemont S				Edge			04 Hen	0.5(5)			Arundel	
3	Funeral			5. Sex 1 □ M 2 및 F	7. Age (In yrs.	last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)	9. 8 7. 7	irthplece (State of Sountry)	or Foreign
	Director		061-38-5312 Usual Residence of Decedent	A	57		1				Jan 7	, 19	4 / N	ew York	
	/land		10a. State 10b. County		10c. Cit	y, Town or La	cation							10d. Inside C	ity Limits
	Man a-1 sh	tor	Maryland Anne A	rundel	I	Edgewat	er							1 ⊠Yes	2 🗆 No
	or 28	lre	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What (	Country?	
	23e	Funeral Director	3554 Edgemont S	treet					037			U.S			
	er deg	une	11. Marital Status	Armed F		.S. 13.	Was Deced If Yes, spec	lent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	D-	14. Race - An Bfack, Wh	nerican Indian, nite, etc.	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	d 1 □ Yes If Yes, G Year or	2 📉 No ive Dates:		1 ☐ Yes	2 <b>∑</b> No	Specify:				Specify: W	hite	
21215-0036	tiled within 72 hours atter death with the Maryland Hygiene. kther than "natural", or Itema 23e or 28a-f show with the Medical Examinat must be notified at	ed t	15. Decedent's		Datos.	16a. Deced	dent's Usua	al Occupa	ation			16b. Ki	nd of Busines	s/Industry	
212	n n 7	Completed	(Specify only highest Elementary/Secondary (0-12)	T	) (1-4or 5+)	16a. Deced (Give life.	kind of wor DO NOT us	rk done d se retired	turing mosi ')	t of workir	ng				
7	filed withi Hygiene. other ther	Som	12	Comogo	2	Regi	ister	ed Nu	ırse			He	alth C	are	
	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, L.								(First, Middle				
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Maryland	2 shd is m		19a. Informant's Name/Relationshi Virginia Padill				3	,			≀Route Numb vie, Ma			. Zip Code) 715	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition	a/SISLEI	20b. F	Place of Dispo	sition (Nan	ne of	!		ete Fic			or Town, State	
Baltimore,	permit. Pages Department of the Important: If ite any injury or of once.		1 ₺ Bunal 2 ☐ Cremation		State	emetery, crer	natory or o	ther plac		one .	1/20/0		20	ille, M	D
돌	artme ortani injury		<ul> <li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lieuward)</li> </ul>		Lar									Funeral	
Ba	Dep Imp		1 Jul P	Smil							1, Bowi				
	48		23a. Part1. Enter the disease, or c shock, or heart failure. List o	complications that	caused the deat	h. Do not ent	er the mod	e of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximat Interval Bet	te tween
E.	Physician		Immediate Cause (Final disease or condition	//	Jel	chit	- 1	red	c (2) (VEd)	cela	- dis	001	0	Onset and	Death
	/Medical		resulting in death)	a. Due to	(or as a conseq	uence of):	- 1 - 1		mg / ->		0.7		<del></del>		
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	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence or):									
In.	xecut and al-trar	xan	that initiated events resulting in death) Last	c	(or as a conseq	uence of):									
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89	uficate g physi as the t	edic													
ŏ	eath certific attending p	M/UE	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Ectopic pr	egnancy				2	23d. Date of d		
m	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (sp						Month	Day	Year
<u>о</u>	The law requires that the de ate has been signed by the a bage 2 should be detached	Physician/Med	9 Unknown \						- in Dani I		220 Did	tohanno u	an anntributa	to the cause of o	donth?
ŝ	w requires that been signed b should be deta	by	Part II. Other significant condition	es contributing to	geath but not res	ulling in the u	ngenying c	ause give	en in Fait i	•		Yes 2[			Unknown
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Ĭ	Physician: r this certifica ral director, i	Be c	25. Was case referred to medical examiner?  ↑★★★ 2 □ No	Hospital:	Inpatient 2	EB/Outpation	* 3 T DC	Othe	25		(Check only		MOther /C-	At s	scene
o	<u>a</u> ≑ <u>a</u>	. To	27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time of		8c. Injury Work	4 🗆 140		ne 5 Resi			ieciry) AL L	300170
on	Attanding I r death. ector: After by the funer	atior	Natural 5 Pending 2 Accident investiga		nth, Day Year)	Injury	М		<br Yes 2 🔲 i	No					
Division of Vital	or Attsndi after death Director: A	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Plac	e of Injury - At he	ome, farm, str	eet, factory	, office		2	8f. Location (			Rural Route Nurr	nber,
ā	ital or A	Cer			3, , , ,										
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical E	Physician: To the xeminer: On the	basis of examina										s)
	the thin 2 the mplet	Med	29b. Signature and title of certifier	and ma	nner stated.		290	. License	number			29d. Dat	e signed (Mo.	nth, Dey, Year)	
)	5.35.8		110	11 11	9 1	1-		C.M.						16, 2004	4
			30. Name and address of person w	no completed car	use death (Iter	n 23a) (Type.									
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97	Sta	ite	31. Date filed (Month, Day, Year)	2004 324	Registrar's Signa	ature	and a	,							
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Discovery of the property of t					For State	State o	of Marylar		artment rtificate			nd Mental Hy	giene Reg. No. (	2004	03060
Process  Secretal Salidate Crooks  Secretal Salidate Hospice  Secretal Salidate  Secretal Sali					Registrar  1. Decedent's Name (First, Middle, L	ast)							eath		3. Time of Death
Section   Sect							ooks								6:45 P M
Joseph Richie Hospice   South Provided		<b>&gt;</b>							4b. City, T	own, or	Location of	Death			
The State   100 County   100 Co			LXanını	e.	Joseph Richie H	ospice			Balt	imor	e e				
10   10   10   10   10   10   10   10			Funeral		Social Security Number 6.		7. Age (In yrs.	last birthday)				Hrs. 8. Date of B	rth ay, Year)	9. Birth Cou	place (State or Foreign intry)
Section of the part of the p						1 <del>M</del> 2 □ F	7.5	5 Yrs.	Worth	Duyo					
John Williams Crooks  Florence Coper  The Lorence C		Pur	3				10c. Ci	tv. Town or Lo	ocation						10d. Inside City Limits
John Williams Crooks  Florence Coper  The Lorence C		lanyte	o ta	ō		Caorga	, ,	Rozzio							1⊠Yes 2□No
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23a Part, Sings the declares, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate inferred large-special properties and continued and con		and de	ed o	o Be	John Williams Cr	ooks					Flor	ence Coop	er		
23a Part, Sings the declares, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate inferred large-special properties and continued and con		Shoul	nd Me mari	1	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (	Street 2				Town, State, Z	ip Code)
23a Part, Sings the declares, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate inferred large-special properties and continued and con		Z 29	27 Is 27 Is r trau		Patricia M. Croo	ks/Wife		2004	Penfi	e1d	Lane,	Bowie, Ma	aryla	nd 207	16
23a Part, Sings the declares, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate inferred large-special properties and continued and con		e i a	f Hea item otha			_	20b.	Place of Dispo	osition (Name	e of her place	e)	Date	20c. Loc	cation - City or T	Town, State
23a Part, Sings the declares, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate inferred large-special properties and continued and con	1 0	E gg	nt: If				State					2/18/2004	Ar1	ington,	Virginia
23a Part, Sings the declares, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate inferred large-special properties and continued and con	25	<b>a</b>	partm porta y inju		21. Signature of Funeral Service Lic	ensee		2	2. Name and	Addres	s of Facility	Robert 1	E. Eva	ans Fun	eral Home,
Physician (Medical Examiner)  Sequentially incombined and past (First mediate Cause) (First mediate) (First mediat	nd	m a			ADL TH	mil		1	16000	Anna	polis	Road, Box	vie, 1	Marylan	1 20715
Due to (or as a consequence of):    Due to (or as a consequence of):	9	Ph	nysician		shock, or heart failure. List on	ly one cause on	each line.		7						Onset and Death
Sequencially list conditions contributing to death but not resulting in the underlying cause given in Part I.    Sequencially list conditions cause the property of the proper		DOM: N			resulting in death)	- 4									1
The second of th		E)	kammer	L	Sequentially list conditions,	b. Due to	(01.00.0.00000	Tuesda of							
The second of th	1	Pa	sit	lne	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	D09 (0	(Or as a conse	querice oi).							
Section   Sect	0	, xecu	and and al-tran	xan	that initiated events	c. Due to	(or as a conse	quence of):							
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State   Stat		O	anding use	N/M		23c. If yes, or	utcome of pregn	ancy	Ectonic pre	onancy			2		
State   Stat	5	Geat Geat	e atte	icla	1 ☐ Yes 2 ☐ No	4∐Preg	nant at time of							Month	Day Year
State   Stat	X	O. at a	by th	h.	-30									. 9	Ab
State   Stat		<b>S,</b>	gned be de		Part II. Other significant conditions	contributing to	death but not re	sulting in the u	inderlying ca	use give	en in Part I.			a .	
State   Stat	0	ord	pino ould	ted									1105 2/2	1 120	
State   Stat	61	ec lawr	as be	ble								aut	opsy	24b. Were au prior to o	topsy findings available completion of cause of
State   Stat	0	E ed	ate h	Con										1 Yes	2 <b>™</b> No
State   Stat	11:	/ita	ertific ector,	0		Hospital:				Oth	25	•			11 - 42 -
State   Stat	7	of o	this caldin	-		1		_		^	4 🗆 1401				in) NE>TICE
28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 29a) (Type, Print)  PRANCIS X - STRAIN III MID 3 CL STRAIN II MID 3 CL STRAIN III MID 3 CL S	+		Afte	lon	1 Natural 5 Pending		nth, Day Year)						, (10 W 11 July	00001100	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 29a) (Type, Print)  RANCIS X STRAIN, III WW 3CI STRAIN BALT MY 217c2  31. Date filled (Month, Day, Year)  32. Polistrar's Signature	67	ivision Attan	ter deat irector: n by the	rtifica	3 Suicide 6 Could not	he -	ce of Injury - At I ding, etc. (Spec	nome, farm, st ify)	reet, factory,	office				d Number or Ru	ral Route Number,
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  FRANCIS X. STRAIN, IT, MD 3cl STRAIN BALT MY 217c2  31. Date filled (Month, Day, Year)  32. Projector's Signature	Ver	Hospital	4 hours a Funeral D ely filled i	ical Ce	(Check only 2 Medical Ex	aminer: On the	basis of examin	owledge, dea ation and/or in	th occurred a	at the tin	ne, date <i>a</i> nd pinion, deatl	place, and due to the occurred at the time	e cause(s) o, date and	and manner as place, and due	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 29a) (Type, Print)  FRANCIS X. STRAIN, III, NID 3CI STRAIN BALT MY 212cZ  State 31. Date filed (Month, Day, Year)  32. Projector's Signature	77	<b>\$</b>	thin 2 the mplet	Med		and ma	Intel Stated.	,	29c.	Licensi	e number		29d. Date	e signed (Month	n, Day, Year)
30. Name and address of person who completed cause of death (Item 2 a) (Type, Print)  FRANCIS X STRAIN, III, NID 301 STRAIN BALT MYD 217c2  State 31. Date filed (Month, Day, Year)  32. Philistran's Signature		°	§ <b>1</b> €	-	255 Organizaro ano majo di consider	XI	16001	, de	D	5	44-	715			
State 31. Date filed (Month, Day, Year) 32. Figistrar's Signature		7				no completed car	use of death /lea	m 2 a) /Tuna	Print\		Their		( -		1
State 31. Date filed (Month, Day, Year) 32. Figistrar's Signature				ŧ i			-	, (Type	LID	3	01 5	TPAUL	131	ter h	W 2170Z
			Sta	ate	31. Date filed (Month, Day, Year)	32.		nature	1 -		P				

		1 - For AMEND#8 1/20/0 State Registrar AACO HEALTH	•	aryland		rtment of H		nd Mer		jiene 19g. No.	2001	030	061
Physic /Medi	cal	Decedent's Name (First, Middle, I     Doris R. Coley     4a. Facility Name (If not institution, g		r)		4b. City, Town, or	Location of [	J	Date of Dea Month	Day y 18	Yeer 2004 County of Deat	3. Time of I	14
Exami Funeral Director		Sade O3 4085 Usual Residence of Decedent		_	st birthday) Yrs.	Annapol If Under 1 Year Months Days	Lis If Under 24	Hrs. 8.	Date of Birth (Month, Day	Year)		del hplace (State or untry) hington	
Maryland	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Anne A	Arundel		Town or Lo				27			10d. Inside Cit	
ie, Mal y idilia ZIZIS-0050 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiene. Ifealth and Menial Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f ehow other traumatic event, the Medical Exams or must be notified at	by Funeral Director	10e. Street and Number  84 N. Old Mill I  11. Marital Status  1 Never Married 2 Married  36 Widowed 4 Divorced	Bottom Road  12. Was Deceder  Armed Forces	1 #201 It Ever in U.S. ??	13. V	10f. Zip Code  21401  Was Decedent of His f Yes, specify Cubar	spanic Origir n, Mexican, f Specify:	n? (Specify Puerto Rica	Yes or No-	Unit	ed Stat 4. Race - Ame Black, White Specify: wh	es rican Indian,	
within 72 hour ene. than "naturel	Completed b	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	Education		(Give life. L	lent's Usual Occupa kind of work done d DO NOT use retired)	uring most o	of working			nd of Business/		
allyidillo Zira	To Be Co	17. Father's Name (First, Middle, La	st) Smith				Ali	ce Ba	irst, Middle,	Maiden .	Sumame)	T- Code	
of the strand 2 shoot of Health and If item 27 le muror or other trauma		19a. Informant's Name/Relationship  Tinda Coley Teat  20a. Method of Disposition	ce/ daught	er 20b. Plac	3300 ce of Dispo	g Address (Street a  Hidden Ri  sition (Name of hatory or other place	iver V		nnapo.	lis,		01	
permit. Pages Department of I Important: If ite any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signature of Funeral Service Lic	cify)	е	imore	Cremator Name and Address	cy Ja s of Facility	John	1. M. '	Tayl	or Fune	ral Hor	
ding Physician: The law requires that the death certificate be executed the second of	dical Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	by one cause on each  a	ed the death. Inc. I S s a consequer is a consequer is a consequer	nce of):	er the mode of dying				est,	-	Approximate Interval Betw Onset and D	reen
the death certify the attending ched for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SNo 9 □ Unknown		e of pregnanc 2 Fetal de at time of dear	eath 3	Ectopic pregnancy Other (specify)				2	3d. Date of deli Month	,	ear
The law requires that the ate has been signed by the page 2 should be detached.	by	Part II. Dther significant conditions	s contributing to death	but not resulti	ing in the ur	nderlying cause give	n in Part I.		1 🗆 Y	es 25	No 3 □ Pro	the cause of de	nknown
VICAL NEC ician: The law sertificate has b ector, page 2 sl	e Completed	25. Was case referred to medical					26. Place of	f Death (C	24a. Was a autops perform 1 Yes	med?	24b. Were au prior to death? 1 ☐ Yes	topsy findings a completion of ca	vailable use of
VISION OF VICE Attending Physician: r death. ector: After this certific by the funeral director,	Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no			NOutpatien 8b. Time of Injury	28c. Injury Work	T: 4 Nursi	ing Home 28d.	5 🗌 Reside	ence 6 ow injury			
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the t	al Certifi	4 Homicide determine	Physician: To the best	etc. (Specify) st of my knowle	edge, death	eet, factory, office	e, date and p	place, and	due to the c	n, State) ause(s)	and manner as	ral Route Numb	· · · · · · · · · · · · · · · · · · ·
To the He within 24 To the Fu	Medical	(Check only 2 Medical €x one)  29b. Signature and title of certifier	aminer: On the basis and manner	or examination stated.	n and/or inv	29c. License	number	occurred a	it the time, d	ate and	signed (Month	Day, Year)	
		30. Name and address of person who	no completed cause of 208	death (Item 2	(3a) (Type	Dring Ch	estr,	m')	21410	\		-	
Si Regis	ate trar	31. Date filed (Month, Day, Year)  JAN 2 0	2004 32. Regis	strar's Signatur	B A	book							

			1 - For State Registrar	State of Marylan	d / Depa		Health and N	Mental Hyg		•	03062			
	Physici /Medie	al	Decedent's Name (First, Middle, Las.     Mohamed Y.      4a. Facility Name (If not institution, give	Cole		4h City Town	or Location of Death	2. Date of Death	103y	2004	3. Time of Death 9:00A M			
3	Examir	ier	6829 Riverdale Rd	#202			verdale			nce Geo	orge's			
	Funeral Director		5. Social Security Number 6. Se 219-57-5522 15 Usual Residence of Decedent	7. Age ( <i>In yr</i> s. 72	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	31 <sup>ar)</sup>	9. Birthp Sieri	lace (State or Foreign fry) a Leone			
	be filed within 72 hours after death with the Maryland tat Hygiene. Id other than "natural", or items 23a or 28a-f show event, tre Medical Evaining must be notified at	Funeral Director	10a. State 10b. County  MD Prince Ge		y, Town or Lo	verdale		10	o Citizan	of What Coun	0d. Inside City Limits 1X Yes 2 □ No			
	th with 23s or	al Di	6829 Riverdale Rd.	#202			20737		. OZ011	USA	,			
920	urs after dea al', or items Examinar m	ρ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🗓 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, o ecify: Blac	etc.			
Maryland 21215-0036	within 72 ho ene. than "natur to Medical I	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retire Clerk	pation during most of work d)	ing	Gov	of Business/Inc	dustry			
land 2	uld be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Abass Salieu	Cole			18. Mother's Nam Khedijati	e (First, Middle, M U		name) dams				
	nd 2 sho alth and 27 Is ma		19a. Informant's Name/Relationship (T) Amadu S. Cole/ Sc		19b. Mailir 6829	ng Address (Street Riverda	and Number or Rur le Rd.	a <i>l Route Number,</i> Riverdale	City or To MD	wn, State, Zip 20737	Code)			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Exteriore must be notified at Once.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Foneral Service Licens	Aku	Moham		1	2/2004	Freet	on-City or To own,Si neral H	ierra Leone			
2	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Carcinoma Prostate  Due to (or as a consequence of):  Due to for as a consequence of it.											
68760,	ficate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t										
.O. Box	The law requires that the death certifica tie has been signed by the attending ph age 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1	death 3	Ectopic pregnancy Other (specify)	,			Date of deliver Month	y Day Year			
<u> </u>	w requires that been signed b should be deta		Part II. Other significant conditions co	ntributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.		accouse c		e cause of death?			
Vital Records,		Completed						24a. Was an autopsy perform 1 Yes 2	1	b. Were autop prior to com death? 1 \(\sum \text{Yes}\)	sy findings available apletion of cause of			
	ysicier s certif directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	fospital: 1 Inpatient 2 I	ER/Outpatien	t 3 DOA Oth	00	h <i>(Check only one</i> me <b>X</b> □ Resider		Other (Specific	1			
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	ertification: T	27. Manner of Death  1 Matural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho	28b. Time of Injury	28c. Injun Wor M 1 🗆	y at k? Yes 2 □ No	28d. Describe how	v injury occ	curred				
Ω	Hospitel or A 24 hours after Funerel Dire tely filled in b	0	4 Homicide determined	building, etc. (Specify	·) 			City or Town,	State)					
	he Hos n 24 ho he Fun oletely f	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exami	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wiedge, death ion and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occurr	and due to the cau led at the time, dat	ise(s) and e and plac	manner as sta e, and due to	ited. the cause(s)			
)	To the within 2 To the complet	ž	29b. Signature and title of certifier	Van Oer		29c. Licenson D018		29	-	ned (Month, D 4/2004				
1	(2)		30. Name and address of person who co Paul A. DeVore, M	mpleted cause of death (Item D 4203 Qt	<sup>23a)</sup> (Type, i ieensbi	Print) ury Rd. H	yattsvill	e, MD 20	781					
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 A 2004	32. Registrar's Signal	ure	,								

				Out (M				•		•	
			1 For State	State of Marylan				id Mental Hy	giene		00000
			Registrar		Cei	rtificate of	Death		Reg. No.	2004	UJUb.
0	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	eath Day	/ Year	3. Time of Death
	/Medic		Thomas Jefferso					Januar	-		12:50A M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town,			4c.	County of Death	
_	T	* <u>.</u> _	Prince George's		f	If I Index 1 Vees	Chever				George's
П	Funeral		5. Social Security Number 6. Sex	IM SETE		If Under 1 Year Months Days		Min. (Month, De	əy, Ye <i>ar)</i>		lace (State or Foreign try)
	Director		578-09-9223		5 Yrs.			June 22	, 19	18   Sout	h Carolina
	yland now		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Mar a-1 at	to	Maryland Prince G	eorge's		Dist	rict He	ighte			1 XYes 2 No
	or 28.	Director	10e. Street and Number			10f. Zip Code	1100	251100	10g. Citi	zen of What Coun	try?
	ours after death with the Marylar rel', or Items 23s or 28s-f show Extralliber Livist be trefithed at		1201 Iron Forge	Road			20747			United S	tates
	ems Frink	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.1	Was Decedent of I	Hispanic Origin	? (Specify Yes or No uerto Rican, etc.)	o-	14. Race - Americ Black, White-	an Indian,
9	or it		1 Never Married 2 Married	1 □XYes 2 □ No If Yes, Give	i	1 ☐ Yes 2 <b>X</b> No		,		Specify: Ame:	
9500-51212		Completed by	3 Vidowed 4 □Divorced	Year or Dates:							
ņ	n 72 "nai	lete	15. Decedent's Edu (Specify only highest grade	completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of	working	16b. Ki	nd of Business/Inc	ustry
7	filed within 72 Hygiene. Nther than "nated ont, the Madic	E C	Elementary/Secondary (0-12) 7th	College (1-4or 5+)		Truck D				Danif na nata	C - £
	be filed within 72 h ital Hygiene id other than "natu event, tip Maccical	ပိ	17. Father's Name (First, Middle, Last)			TIUCK D		Name (First, Middle			- Safeway
a	id be ental ked o	To Be	Arthur Crestw	e11				Dor	a Be	lcher	
Maryland	should nd Men marke umetic	-	19a. Iñformant's Name/Relationship (Ty	pe, Print)	19b. Mailin	ng Address (Street	t and Number o	or Rural Route Numb			Code)
	nd 2 aith a 27 is		Channce Allen -	Grandson				., Distri			
Baltimore,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Lo	cation - City or To	wn, State
Ë			1 ☐ Burial 2 ☐ Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	_	Cremator		13/2004		Clinton,	MD
<u>=</u>	그 든 본 중		21. Signature of Funeral Service License	^				Stewart	Fune	ral Home	1110
ñ	Depa Impo eny ir		10hw 1. 2	III. Iroush				Rd., N.E.			20019
1.5	b		23a. Part1. Ener the disease, or compli shock, a heart failure. List only or	cations that caused the death	h. Do not ent	er the mode of dyi	ng, such as car	diac or respiratory a	rrest,		Approximate Interval Between
, C	Physician		Immediate Cau e (Final disease or on ition							care l	Onset and Death
	/Medical		resulting in (ash)	END S  Due to (or as a consequence of the consequen	uence of):	-	CE/07	7_ /_	), Je	THE	
	Examiner		Conventially list appolitions	MYOCAN	-P14	_ //	NFA	RC770	N		
13		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that influence to the control of	Due to (or as a consequ	uence or):						
	nd rans	Examiner	triat irritiated events	SEPSI						347	
/60,	e be executed sician and e burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
	9 × 9	lical						-			
200	death certificat e attending phy d for use as the	Physician/Med	IF FEMALE:								
žog	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Fetal	death 3	Ectopic pregnanc	у		2	3d. Date of deliver Month	ry Day Year
- -	the de	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (specify) _				N.O.	Jay Tour
<u>.</u>	that the de sed by the a detached f	P	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	adarhina cauca an	uan in Part I	23a Did	obacco u	se contribute to the	a cause of death?
က်	8 5 6	l by	, at the second	moding to obtain but not repor	annig in the di	loonying causa gir	vent act to				ibly 4 MUnknown
Kecords		Completed									
ě	The law ite has b age 2 s	idu						_ 24a. Was	DSV	24b. Were autop	sy findings available pletion of cause of
<u></u>	r. Th							1 Yes	rmed? 2. ♣No	death?	2 □ No
Vital	Physician: The law r this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	ospital:	935	0#		Death (Check only of			
5	this de	-T	1 Yes 2 No	1 ☑ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien 28b. Time of	1 3 DOA	4 🗀 Nursin	ng Home 5 Resident			
0	ding P. Afte fune	fon	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk? Yes 2 □ No	28d. Describe I	now injury	Occurred	
UIVISION	2 0 >	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me, farm, stre		,	28f. Location (	Street and	d Number or Rural	Route Number
$\leq$	i Dire	Certification:	4 Homicide	building, etc. (Specify	()	out, rectory, critical		City or To	wn, State)	7,147,150, 0, 7,474,	riodio reambor,
	urs ered		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge, death	occurred at the ti	me, date and ol	lace, and due to the	cause(s)	and manner as sta	ited.
		Medical	(Check only 2 Medical Examination)	ner: On the basis of examinat and manner stated.	tion and/or inv	estigation, in my o	opinion, death o	occurred at the time,	date and	place, and due to	the cause(s)
	To the within ? To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	signed (Month, D	ey, Year)
			1		MI	D5	818	2	Ja	nuary 9,	2004
0	(7)		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)					
1			Donald George	, M.D. 12902	2 Hawks	shead Ter	r., Sil	lver Sprir	ng, M	D 20904	
ı	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa							
	Registr	ar	JAN 1 5 2004	The same of the	Trans.						

			1 - For State Registrar		S	state o	f Mary		epartme Certifica				Mental H	ygiei Reg.	1	004	0306	L
	Physici	an	Decedent's Nan	ne (First, Middle	e, Last)								2. Date of D	Death		<i>Ž</i> 004	3. Time of Death 12:34A	
	/Medio	cal	Ka 4a. Facility Name	arl Antl					45 0%	. T	-1	( D	1 4	arg	12,		12.377	м
	Examir	ner '							40. Cit			on of Death	1			ty of Death	a 1	
	Funeral		5. Social Security	S Commu	6. Sex	nosi		yrs. last birth	fay) If Und		anha ∐ If Un	der 24 Hrs.	_ 8. Date of B	Birth			George's lace (State or Fore	ian
	Director		577-94-	-7323	1 🔀 M	2□ F		42 Yr	Months	Days	Hou	rs Min.	Dec. 2	<i>Јау, Үө</i>			h., DC	3
	P.		Usual Residence	of Decedent									pcc. 2	,			entant	
-1	72 hours after death with the Maryland Insturel; or Itema 23e or 28a-f show Licel Examinal must be notified at	'n	10a. State Maryland	10b. County	re Geo	nroe	1	c. City, Town o		r Ma:	r1ha	nro.				1	0d. Inside City Limi 1 Yes 2 ☐ 1	
W	2 hours after death with the Maryla atural; or itama 23e or 28e1 shov	Director	10e. Street and No							ip Code	LID	710		100	Citizana	f What Coun		-
	with with	ā		Campus	Mass (	South			101. 2	ib Code	20	)774		log.			,	
Š	after death w or itema 23e	era	11. Marital Status	Campus	12.	Was Dece	edent Ever	in U.S.	13. Was Dec	edent of H			pecify Yes or No Rican, etc.)	No-	_	nited	States an Indian,	
2 9	or iter	Fur		ried 2 Marr	ied	Armed Fo	2 💢 No						Rican, etc.)		ВІ	ack, White,	etc.	
14 CARPEN TE. 21215-0036	ours a	Be Completed by Funeral	3 Widowed	4X Divorced		If Yes, Giv Year or D			1 🗆 Yes	2 <b>X</b> I No	Spec	cify:			Spec	ify: Bla	ck	
0 4	72 hours natural;	etec	(Spe	15. Decedent ecify only highes	t's Educations of the Education of the E	on ompleted)		(0	ecedent's Us give kind of w	ork done	durina n	nost of won	king	16b	. Kind of	Business/Inc	lustry	
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200	d be sental	o Be		ar1 M. (		nter					10. 111	7(110) 3 14 <u>u</u> 1	Marg			iiio)		
10thor	2 should be filed within and Mental Hygiene. Is marked othar than aumatic event, the Mental Control of the Men	T <sub>0</sub>	19a. Informant's N		_			19b. N	lailing Addres	s (Street a	and Nui	mber or Ru	ral Route Num			n. State. Zio	Code)	
Anthony  B. Marviand 21	permit. Pages 1 and 2 should be filed within Inportant: It item 27 is marked other than any injury or other traumatic event, ILAM 2006.		Margo	C. Jone	es - 1	Mothe	r						Capitol				20743	
J. j.	of Hei		20a. Method of Dis					Ob. Place of D	isposition (Na	ame of other plac	ca)	1	Date	20c.	Location	- City or To	wn, State	
$\frac{dr}{dr}$	Page nent c int: If		1 LXBurial 2 4 □Donation	! ☐ Cremation 5 ☐ Other (S <sub>i</sub>		oval from		Mt. 01	•			1/19	/2004		Wash	DC		
alti	permit. Departnimports		21. Signature of	uneral Service	Licensee	A			22. Name a				tewart	Fur				
A B	8978		) oh	MI	Shur	ail	IIL						l., N.E		sh.,	DC :	20019	
			23a. Part 1 Enter shock or hei Immediate Cause	art fallure. List	complicationly one c	ause on e	ach line.			de of dyin	ıg, such	as cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death	
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	Examiner		WINDS CONTROL FROM THE			CH	RUN	rsequence of)	ENRI	1	FAT!	lune					5 4,500	J .
C.		Jer	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or	onditions, mmediate	b. —	Due 10 (	(OI as a COII	sadnauca oil									TWO MON	
	cuted nd ransir	Examiner	that initiated event	(S	c	An	50 ×	1C	ENC	SPH.	AL	OPMI	HY				TWO Ma	I.
0	e exe ian aı urial-t		resulting in death)	Last		Due to (	or as a con	rsequence of)										
8760.	cate be executed physician and the burial-transit	dlcal			d					<del></del>								
9	E Dog	a a	IF FEMALE:		220	M upp out	some of our									-		
Bo	that the death certifed by the attending detached for use a	lan	23b. Was deceder in the past 12	2 months?		1 Live b	come of pre inth 2 1 1 ant at time	Fetal death	3 Ectopic		,					ate of deliver onth	У Day Year	
Ö	the de	yslo	1 ☐ Yes 2 9 ☐ Unknow			9 Unkno		or death	5 Other (s	респу)								
ط ا	Physician: The law requires that the death certifit this certificate has been signed by the attending ral director, page 2 should be detached for use as	by Physician/M	Part II. Other signi							cause give	en in Pa	irt I.	23e. Did	tobacc	o use cor	tribute to the	cause of death?	
rds	w requires been sign should be	q p	DILA	( CT	MRI	100	ry o f	ATH	1				1 🗆	Yes	2 110	3 🗌 Proba	ıbly 4 ∐Unknow	m
Ö	s been should	Completed	MUP	ER TE	N Si	'ON		,					24a. Wa	s an	24b.	Were autop	sy findings availab	le
Be	The lav	mo											perf	opsy ormed?	· /	death?	sy findings availab optetion of cause of	
ita	ician: The certificate rector, pag	BeC	25. Was case refe	rred to medical			-				26. Pk	ace of Deat	1 ☐ Yes		40	1 □ Yes	ZUZTNO	-
>	Physici this cer al direc	To B	examiner?	No.	Hosp	oital:	npatient	2 ER/Outpa	itient 3 D	OA Othe	O.C.		me 5□Res		6 □Ot	her (Specify)		
0	ding Pt J. After th funeral		27. Manner of Dea	ith 5 🗌 Pendin		8a. Date of	of Injury h, Day Yea	28b. Tim	e of	28c. Injury Work	y at k?		28d. Describe	how in	jury occu	rred		
Sio	Attending r death. sctor: After oy the fune	catio	2 Accident	investig	ation				М	1 🗆 \	Yes 2	□No						
Division of Vital Records, P.O. Box	after d Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide	determi	ined 2	8e. Ptace buildir	of Injury - Ang, etc. (Sp	At home, farm becify)	, street, facto	y, office			28f. Location City or To	(Street own, Sta	and Num ate)	ber or Rural	Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)	1 Certifyin 2 Medical	g Physicia Examiner:	on: To the On the ba	asis of exam	knowledge, d	eath occurred r investigatio	at the tim	ne, date pinion, d	and place, death occur	and due to the	cause,	(s) and m	anner as sta	ited. the cause(s)	
_	ro the within 2 Fo the comple	Mec	OOL Cinner	Stitle of certifier		-1	1111		29	c. License	e numbe	er e		29d. D	ate signe	ed (Month, D	lay, Year)	
	⊢ 3 ⊢ ŏ		> 1/4	Dun 1	8	11/1	1/ 11	4		9	41	124	0		01	/13/	20066	
0.10	(2)		30. Name and add	ress of person	who compl	eted caus	e of death (	(Item 23a) (Tv	pe. Print)	, , ,	,				- 1	1 101.	7	
UK	(2)		30. Name and add	W S	M17	H,	290	5 Mi	TONE	10,14	e R	CAG	#104	, 2	BOW	1e. 1	NO 207/1	6
'	Sta	ite	31. Date filed (Mor	nth, Day, Year)	14	32. R	egistrar's S	ignature										

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 27, 6:20 A M January 2004 Russe11 Gilbert Dent /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F 577-40-4304 Yrs January 27, 1931 Washington, 73 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show Examiner must be netified at 1 Yes 2 No Director Mary1and Howard Savage 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 5 8914 River Island Drive 20763 USA items 23a Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumation. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Entomologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Conn Wade Gilbert Dent, Jr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Trails End Greenville, SC Douglas F. Dent Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Alexandria, Virginia 28, 2004 Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home P.O. Box 270 Leonardtown, MD 206 21. Signaty of Funeral Service Licensee Frichael Keven 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician 2 Days Sepsis resulting in death) /Medical Due to (or as a consequence of): **Examiner** 2 Davs Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attanding Physician; The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Be Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day detached for 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 🔀 Unknown Renal Failure 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 2□ No 2X No 1 ☐ Yes the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 ☐ Yes 2 X No 3□ DOA Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUARY 274,04 10052927 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 832 Muddy Branch Rd. Gaithersburg, MD Theodore Igwebe 31. Date filed (Month, Day Year) 32. Regissar's Signature Registrar

		1 - For State Registrar	State of M	/larylan		artmen rtificate				F	leg. No.	004	03	06
Physici /Medi		Decedent's Name (First, Middle, Letter)     Clayton Dixon	ast)							2. Date of Dea Month Januar	Day y 3, 20	Year <b>004</b>	3. Time of 12:2	25 P M
Examir		4a. Facility Name (If not institution, gi		r)		,		Location o				ty of Death		
	365	Bayside Care Ce 5. Social Security Number 6.		Ana (In vrs	last birthday)	Lex:		on Pa		3. Date of Birt		9. Birtho		or Foreign
Funeral Director		235-18-5742	1 <b>X</b> M 2□F	82	Yrs.	Months	Days	Hours	Min.	(Month, Day	, Year) 23, 192		lace (State try) t Vir	
yland		Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						11	0d. Inside 0	1 14 4 700
e Mai	cto	Maryland Saint M	ary's	Lex	cingto									s XXNo
or 28	Directo	10e. Street and Number				10f. Zip	Code				10g. Citizen of		try?	
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23e or 28e-f ahow other traumatic event, the Medical Exeminer must be notified at	by Funerai	21413 Lynn Driv  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 17 Yes 2 I If Yes, Give Year or Date	s? ⊒ No			offy Cuba	ispanic Ori in, Mexicar Specity:	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)		ace - Americ ack, White,	etc.	
n 72 ho "natur	Completed	15. Decedent's I (Specify only highest g	rade completed)		16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired	ation during mos f)	t of working	g	16b. Kind of			
within them	l iii	Elementary/Secondary (0-12)	College (1-4d	or 5+)		ief Pe					U.S. N	Navv		
tilled tillygiother onther	a	17. Father's Name (First, Middle, Las	:1)		,					(First, Middle,	Maiden Suma			
uld be Menta rrked	To B	Leslie Dixon						Nan	су На	rrison				
2 sho and h is ma		19a. Informant's Name/Relationship									r, City or Town			
and and m 27 her tr		Clayton T. Dixon	/ Son	205 [			-		oad L		on Park			2065
ges 1 t of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from Sta	160	Place of Dispo cemetery, cre							•		
t. Pa tmen tent: njury		`4 □Donation 5 □ Other (Spec		Bri	insfie]						Charlot			
permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tra		21. Signatural Survey of Edward N. Brinsi	ield, Jr.	м000							l Funer ardtown			
Physician /Medical Examiner  e pe executed pural-transit e prival-transit	Examiner	23a. Part. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	line.	quence of):	er the mod	e or dyin	est.	cardiac or	respiratory ar	idoli,		Approxima Interval Be Onset and	etween
death certifical e attending phy	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Feta t at time of c	al death 3	⊒Ectopic pi ⊒ Other (sp		1		Tu	N	Date of delive	Day	Year
uires tha signed d be del	by	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the t	inderlying o	ause giv	en in Part I	l.		obacco use co res 2 No	ntribute to th 3 ☐ Prob		death?
e la has	Completed	Disbetts	Millibe	2 N							rmed?_	o. Were auto prior to cor death? 1 \( \sum \text{Yes}	psy finding	s available cause of
	0	25. Was case referred to medical	Varien	1 de	sease			26. Place	e of Death	1 ☐ Yes (Check only o	2 XXV0	10185	2000	
ing Phys	on: To B	examiner? 1   Yes 2   27. Manner of Death 1   A Retural   5   Pending	28a. Date of (Month,		ER/Outpatie 28b. Time of Injury	of 2	28c. Injur Wor	4 DOWN	2		dence 6 🗆 O		y)	
to the the	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At h	oome, farm, st	M reet, factor		163 2		8f. Location (8 City or Tox	Street and Nun vn, State)	n <i>ber or Rur</i> a	l Route Nu	mber,
Hospit 4 hours Funere ely fille	edical C		Physicien: To the basiner: On the basiner: and manner	s of examina										(s)
To the within 2 To the complete	Meg	29b. Signature and title of certifier	1			29	c. Licens	e number			29d. Date sign	ned (Month,	Day, Year)	
⊢≶⊢ŏ		1	1				DIG	9917	)		1/5	10	4	
		30. Name and address of person wh	completed cause	of death (Ite	m 23a) (Type		011	, , /			1/	//		
		James C. Boyd 2			ch Roa		ifor	nia.	Md					
Si Regis	tate trar	31. Date filed (Month, Day, Year)  JAN 0	6 2004	istrar's Sign	ature	boom								

			State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2004 03067
	Dhusisis		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year  3. Time of Death
	Physicia /Medic		Robert Ellis Dayhoff January 13, 2004 10:20 A <sup>M</sup>
	Examine	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Control 1
			Carroll Hospital Center Westminster Carroll  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min. 1 Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Jan 9, 1931 9. Birthplace (State or Foreign (Month, Day, Year) Jan 9, 1931 Maryland
7			Usual Residence of Decedent
J- Slan	how	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Ma Ma	alflex	cto	MD Carroll Woodbine 1□Yes 2√XNo
	or 2	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
OBERT OBERT	e 23e	rai	6824 Woodbine Road 21797 United States  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
	rer	ŭn.	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
) 36 36 Jrs af	atural; or iteme 23a or 28a-f sho cal Examinar must be nutified at	by F	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 1 ☑ Yes 2 □ No 1 □ Yes 2 ☑ No Specify: Specify: White
5-003	"natural", or lieme 23a or 28a-f show	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)  16b. Kind of Business/Industry
721.	- Wad	nple	Elementary/Secondary (0-12) College (1-4or 5+)
4 2 d d d d d d d d d d d d d d d d d d	ygien ner th	Co	12 Carpenter Johns Hopkins APL  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
bus and	of oth	Be	Management Domboff
DAYHOFF, Maryland 21215-0036	is marked other than eumatic event, the M	2	Unknown  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Na Na	treur		Evelyn R. Dayhoff Wife 6824 Woodbine Rd. Woodbine, MD 21797
<b>.</b> 5	of Health and Mental Hygene item and item and item 27 is marked other than "n other treumatic event, the Media		20a. Method of Disposition 20b. Place of Disposition (Name of Disposition (Name of Disposition City or Town, State
mo Page	not of or		1 ▼Burial 2 □ Cremation 3 □ Removal from State  1 ▼Burial 2 □ Cremation 3 □ Removal from State  1 ▼Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  2 □ Cremation 5 □ Cremati
Baltimore,	Department of Important: If it is eny injury or conce.		21. Swnatule of Funeral Service Licensee 22. Name and Address of Facility Burrier—Queen Funeral Directors 1212 W. Old Liberty Road
<b>6</b> 8	8553		Winfield, Maryland 21784
4	13 SA		233 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death
	hysician		Immediate cause (Final desains of condition as Congestive Cardway opening and Stage (Year
	/Medical xaminer		Due to (or as a consequence of):
		ē	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):
petn	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C.
60, be executed	sician and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):
<b>~</b> 9	2 2 2	lical	d
x 68	attending phy for use as th	by Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
Box	atten	clan	235. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?  4 Prognant at time of death 5 Other (coeding)
O.	ed by the atte	nysi	1   Yes 2   No 9   Unknown 9   Unknown
<b>O</b> is	igned t	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
rds	been sig	ed k	1 Yes 2 No 3 Probably 4 Tunknown
ecc Base	as be 2 sho	Completed	24a. Was an autopsy findings available prior to completion of cause of
<u>~</u>	ate ha	Com	performed? death?  1 Yes 2 No 1 Yes 2 No
/ita	After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital: All All All All All All All All All A
of	this aldir	2	To res 20 No To inpatient 20 Envolupation 30 DOA 40 Nursing Home 50 Hesidence 60 Other (Specify)
on Big	h. After funer	tlon	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident Investigation  28a. Date of Injury 28b. Time of Injury 4 Work?  1 Natural 5 Pending (Month, Day Year)  1 Yes 2 No
Division of Vital Records,	r death.	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)
בַּ בַּ	s afte s afte et Dir	Certification:	4 Hornicos Bulluling, etc. (Specify)
Division of Vital Records, P.O. Box 68	lo the hospital of Attent within 24 hours after death To the Funeret Director: completely filled in by the	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	WILLA		1 bech MD D 52035 Jan 13 2004
	10,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SINT CHACKO 291 Stones Avenue Wermung M9 2/157
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Registr	28	JAN 1 6 2004 Seem & Sparks
DHMI	IH 17 Rev 1/2	001	ORIGINAL

			1 - For State Registrar Amend Item#13pe	State of Maryland / Departments / Department	artment of Health and I rtificate of Death		ene 2004	03068
	0.		Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medic		Sammie D. Doro	ough		Jan. 20	Day 2004	2:00A м
	Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	1	4c. County of Death	
3.			13505 Swindler		Mt. Victoria		Char1e	
3	Funeral		5. Social Security Number 6. Sex	M 2 F _ Vrs	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	(Month, Day, Y		plece (State or Foreign ntry)
e på	Director		250-72-5297 Usual Residence of Decedent	59		August	28, 1944	NC
	show		10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	Man 9-1-81	ţċ	MD Charl	es Mt. Vi	ctoria			1 □ Yes 2½∑ No
	or 28	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cou	ntry?
	th will	aic	13505 Swindler	Rd.	20661		USA	
	tems rrm	Funerai	TI. Walkar Olatos	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
36	or I	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 to Yes 2 No If Yes, Give 1966 – Year or Dates: 1966 –	1 ☐ Yes 2X No Specify:		Specify:	
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28e-f show ts Mudical Exural er mast ke notified at	ed b	15. Decedent's Educ		dent's Usual Occupation	16	6b. Kind of Business/lr	nite ndustry
15	n na	Completed	(Specify only highest grade	completed) (Give	kind of work done during most of wor DO NOT use retired)	king		,
212	with a second	E O	Elementary/Secondary (0-12)	College (1-4or 5+) We	1der		Welding	
b	othe othe vent,	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Ma		
/lai	Ments Ments arked	Tof	Cleo Dorough		Sue Ho	lden		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-1 show other traumatic event, the Medical Extralment must be neutilied at		19a. Informant's Name/Relationship (Ty)	oe, Print) 19b. Maili	ng Address (Street and Number or Ru	ral Route Number, (	City or Town, State, Zi	o Code)
	1 and 2 Health tem 27 l		Mary Dorough/ Wi	fe P.O.	Box 1033 La P.			
Baltimore,	0 0 = 5		20a. Method of Disposition  1	cametany cra	matory or other place)	Date 20	Oc. Location - City or T	own, State
Ë	permit. Pag Department Importent: I eny injury c		*4 □ Donation 5 □ Other (Specify)	Holy Gho	ost CemeteryJar	. 23,20	04 Issue	e, MD
Bal	permit. Departr Import. eny inju		21. Signature of Funeral Service License	M00945	2 Name and Address of Facility rehart-Echols 11 St. Mary's	Funeral_	Home, P.	A .
	22200		23a Part 1 Enter the disease or compli	cations that caused the death. Do not en				20646 Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		or rospiratory arros		Interval Between Onset and Death
3	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	«			months
	Examiner			to have use				years
		er	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to (or as a consequence of).				year)
	uted d ansit	Examiner	Cause (Disease or injury that initiated events					
oʻ	en an en an irial-ti	EX	resulting in death) Łast	Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial transit	dical						
9	death certifica attending ph I for use as th	Med	IF FEMALE:					
Box	ath ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of deliv	ery Day Year
	the a	/slc	1 Yes 2 No	4☐Pregnant at time of death 5[ 9☐ Unknown	Other (specify)			
P.0	that the death cerred by the attendindes detached for use	P		stributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
ds,	signed of	d by	chronic dos	tuction gulmona	u disease	1 □ ¥es	2 □ No 3 □ Prof	babiy 4 Unknown
Ö	w requir been s should	ete				24a. Was an	24h Were auto	opsy findings available
Re	he lav	Completed			· · · · · · · · · · · · · · · · · · ·	autopsy performe	prior to co	impletion of cause of
Vital Records,	icien: Th certificate rector, pag		25. Was case referred to medical		26 Place of Dea	th (Check only one)	No 1 ☐ Yes	2L No
5	Physicien: this certificatal director, particular	To Be	examiner?	lospital:	Othor		ce 6 □Other (Special	(v)
of	g Phys er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how		,,
Division	Attending F death. ctor: After y the funer	Certification:	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation	(, -2, -22,,	M 1 Yes 2 No			
Νį	l or Atte after de Directo	tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, structure building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
	itel o							
	Hosp 4 hou Fune Fune	edical	(Check only 2 Medical Examin	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in	th occurred at the time, date and place evestigation, in my opinion, death occu	, and due to the cau rred at the time, date	ise(s) and manner as s e and place, and due t	stated. o the cause(s)
	To the Hospitel or Attending Physicien: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	290	d. Date signed (Month,	Day, Year)
	F 3 2 8		) A ( O	- AA A	D5359~		01/20/04	
(			30 Name and address of person who on	impleted cause of death (Item 23a) (Type,			-1120107	-
1	2751			RENCE , MD 1	2070 OLD LINE CTIL	79 IN WAI	COSULS WO 3	6602
	Sta	ate	31. Date filed (Month, Day, Year) JAN 2 2 20	32. Registrar's Signature	1 4			
	Regist		JAN Z Z Z	109 Alaue S. A	per			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** LaVon B. DuSold Jan. 2004 8:52 a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FutureCare Chesapeake Arnold Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Months 1 □ M 2 1 P 82 May 31, 1919 Director 509-18-8786 KS Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neture" any injury or other trauments. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD 1 ☐ Yes 2 ☑ No Anne Arundel Arnold Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 305 College Parkway 21012 LISA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married White 1 ☐ Yes 22 No Specify: Completed by 3 ₩idowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary 12 Federal Government 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Duncan Mabel Tiffeny ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Delbert DuSold/Son 766 Mago Vista Road, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 21 20c. Location - City or Town, State 20a, Method of Disposition Jan. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

`4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Mem. Ocala, FL 2004 21. Signature of Funeral Service Incensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. ritchie Hwy, Severna Park, MD 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. cerebrovascular accide Immediate Cause (Final disease or condition resulting in death) recurre year **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1☐Live birth Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown detached signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. Completed by 4 Unknown 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Tes 2 No this certificate 1□ Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. Accident investigation filled in by the Director 6 ☐ Could not be determined 3 🗀 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funerel Direct 4 Homicide 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 94 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and Name and address State Registrar

State of Maryland / Department of Health and Mental Hygiene

				State of Ivid	arylaric	-	rtificate of		R	eg. No. 2 ()	04 0	3070
	51		1. Decedent's Name (First, Middle, Last)	)					2. Date of Deat Month	th Day	Mana	me of Death
	Physicia /Medic	al .	GEORGE WILLIAM						1/11/			30 PM
	Examin		4a Facility Nama (If not institution, giva	street and number)				4b. City, Town, or L		4c. County		
			ATRIA	7.4-	- (In In	ast birthday)	If Under 1 Year	SALISBU If Under 24 Hrs.	JRY 8 Date of Birth	WICOM		State or Foreign
	Funeral Director		5. Social Security Number 186-07-5727  Usual Residence of Decedent	M 2□ F	90	Yrs.	Months Days		8. Date of Birth (Month, Day 7/4/13	Year)	9. Birthplace (S Country) DE •	
	pue,		10a. State 10b. County		10c. City	, Town or Lo	ocation					ide City Limits
	May 1	ğ	MD WICOMIC	90	SALI	SBURY	7				A	Yes 2□No
	within 72 hours after deeth with the Maryland ene. than "naturel", or ferme 23a or 28e-f ehow the Madical Exerciner must be notified at	Complated by Funaral Director	10e. Street and Number				10f. Zip Coda		1	0g. Citizen of V	Vhat Country?	
	23a	<u>e</u>	1110 HEALTHWAY			140	21801	Historia Osiais (Ca	U	SA 14 Back	e - American Indi	ian
	9 6	S S	11. Medical Guardo	12. Was Decedent Armed Forces? 1 (X)Yes 2 □ I	193	3	If Yes, specify Cut	Hispanic Origin? (Sp pan, Maxican, Puerto	Rican, etc.)	Blac	k, White, atc.	,
20	a aft	7	1 Never Married 2 Married 3 X Widowed 4 Divorced	If Yes, Giva Year or Dates:	193	6	1□Yas 2∏XNo	Specify:		Specific	HITE	
21215-0020	2 hou	8	15. Decedent's Edu	cation	1	16a. Dece	dent's Usual Occu	pation	kina		siness/Industry	
215	P	pla	(Specify only highest grad Elementary/Secondary (0-12)	a completed) College (1-4or !	5+)	life.	DO NOT use retire	during most of work ed)	"" C	HESAPE	AKE & TELEP	HONE
2	A P P P P P P P P P P P P P P P P P P P	S S	12			SUPE	RVISOR					
Pu	d le de la	å	17. Father's Nama (First, Middle, Last)					18. Mother's Nam		Maigen Surnam	θ)	
Maryland	Men Merke Method	ရ	GEORGE MESSICK		_	10b Maili	na Address (Stree	NETTIE  et and Number or Ru		r. City or Town.	State. Zio Code)	1
Ma	treur	- 1	19a. Informant's Name/Relationship (7)	-		7.0		NANTICO				
ō,	Heeling The The		20a. Method of Disposition	ON	-	non of Dieno	osition (Name of matory or other pla	1	The latest spine of the la		City or Town, St	ate
Baltimore,	permit. Pegas 1 and 2 should be filed within 72 Department of Heelih end Mental Hyglene. Important: If Hem 27 ie marked other than "na eny lijury or other treumatic event, the Media page.		1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	SAL	TSBUI	RY CREM	ATORY 1	./13/04	SALIS	BURY, M	ID
=======================================	artm. Portan		21. Signature of Funeral Service Licens	ee	0041	c 2	2. Name and Addr	ess of Facility	HOME	DO DOM		
ä	P E B		1 grape The rich	M ⊋>	0041			FUNERAL MD 2181		PO BOX	. 01	
			23a. Part1. Entar the disease, or composhock, or heart failura. List only o	lications that cause	d the death	. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory are	rest,	Interv	oximate ral Between
No. of Street, or other Persons	Physician										Onse	t and Death
	/Medical		Immediata Cause (Final disease or condition resulting in death)	a Amery	sall	whi	call	bovasul	14 013	MAK		
	1.00	ايرا	resulting in death)		Due to (or	ras a conse	quence of):					
	nsit	Examinar	•	b	Due to for	as a conse	anabas at).				1	
Ć,	execu in end fel-tre	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or	as a conse	querice ory.				ı,	
68760,	tificate be executed og physician end as the buriel-frensit	edical	Cause (Disease or injury that initiated events resulting in death) Last	C	Dua to (or	as a consec	quence of):					
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Вох	ath ce ttendi	by Physician/M		d							1	
	the e	ysic	Part II. Other significant conditions co					iven in Part I.			ntribute to the c	
P.0	that the ed by datac	H <sub>P</sub>	Alzie uu	45 1	FU	uen	Mg		יטי	res ZLINO	3 Probably	4 (golikilowii
ds	r raquires that the death cer been signed by the ettendir should be datached for usa								24a. Was	an autopsy med?	24b. Were aut	topsy findings
9	A raq	late							penoi	meu ?	complete of death?	on of cause
Be	sicien: The law certificate has b lirector, pege 2 s	Complated							154	es 2010	1 ☐ Yes	212 No
ta	en: T tiflcat tor. p	Bec	25. Was case referred to medical						ath (Check only o			
<b>\S</b>	> 0	<b>To E</b>	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpati	-	ER/Outpatie	INT SLI DOA					16/34hN14
0	ng Phy ter thi		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Data of Inju (Month, Da	ury ay Year)	28b. Tima o Injury	W		28d. Describe h	ow injury occur	red	
SIO	eath. or: After the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			60		⊒Yes 2□No	28f Location (S	Street and Numb	er or Rural Rout	te Number.
Division of Vital Records,	or Attend efter death Director:	E	4 Homicide detarmined	286. Place of in	tc. (Specify		treet, factory, office	Ð	City or Tow	n, State)	, o, o, i i ura, i i u a	
	A Hospital or At 24 hours after of Funeral Direction by Filled in by	edical Certification:	29a. Certifier 1 Certifying Pny	rsician: To the besi	or my know	wiedge, deal	th occurred at the	time, date and place	, and due to the c	ause(s) and ma	anner as stated.	
	To the Hospital within 24 hours of To the Funeral completely filled	dic	(Check only 2   Medical Exam	iner: On the basis of and manner s	of examinat	tion and/or in	nvestigation, in my	opinion, death occu	rred at the time,	date and place,	and due to the c	ause(s)
	To the within To the comple	M	29b. Signature and title of certifier				1	nse number		•	d (Month, Day, )	Year)
				ornale				32014		1/13/0		_
16							, Print)		1.200.	1 /1 1	1 210	11
) JA	<u> </u>		30. Nama and address of person who of MAMESH MODULES 31. Data filed (Month, Day, Year)	va 100	MI	IPOVO	151-5	045591	15 15 4 00	y mi	0100	7
	St: Regist		31. Data filed (Month, Day, Year)	32. Regist	rars Signa	ture 1	Spon	h				

			1 - For State Registrar	State of M	laryland / D	epartmer Certificat				ental Hy	/gien Reg. N	20	04	03072		
-	Dhomini		1. Decedent's Name (First, Middle, La	st)						2. Date of D Month		av	Yeer	3. Time of Death		
	Physici /Medio		ALMA M.	DORSEY						ANUAR'	- T		004	9:20 A M		
	Examir	er	4a. Facility Name (If not institution, given 202 SPESUTIA ROAL		r)		Town, or ERRYN	Location of	of Death		4	,	of Death			
_			5. Social Security Number 6. S		ge (In yrs. last birth		r 1 Year	If Under	24 Hrs.	8. Date of Bi	irth			place (State or Foreign		
	Funeral Director			□M 2 <b>X</b> F		rs. Months	Days	Hours	Min.	8. Date of 8i (Month, D Feb 26	ay, Year	16	Con	yland		
	P _		Usual Residence of Decedent		T						·					
	ehow	5	10a. State 10b. County	£3	10c. City, Town									10d. Inside City Limits 1 ☐ Yes 2 No		
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	death	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces		13. Was Dece	dent of Hi	spanic Ori	igin? (Spec	rify Yes or N	0-	14. Rac	e - Americ	can Indian,		
9	after or Ite	/Fu	1 Never Married 2 Married	1 Tes 20		1 ☐ Yes		Specify:	n, Puerto R	ncan, ecc.)			ck, White, y: Bla			
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f ehow he Madical Examiner must be multied at	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates							101					
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ğ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: If item 27 le marked other than "natural", or Iteme 23a or 28a-f show appring or other traumatic event, the Maclical Examiner must be notified at ance.	Bec	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle	e, Maide	n Suman	n <i>e)</i>			
<u>yla</u> i	Ments Ments arked	To	Allen Dorsey					Lill	ie J.	Ring	gold					
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Baltimore,	ertme ortan injury	1	21. Signature of Funeral Service Licer	Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  20c. Location - City or Town, State (Incomparison)  20b. Place of Disposition (Name of cemtery, crematory or other place)  20b. Place of Disposition (Name of cemtery, crematory or other place)  20b. Place of Disposition (Name of cemtery, crematory or other place)  20c. Location - City or Town, State  20c. Location												
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only													
	Physician		Immediate Cause (Final disease or condition			1 Carc	nema	· of	Sir	145				Onset and Death		
7	/Medical Examiner		resulting in death)	Dy to (or a	s a consequence o	):								1		
	LAdiiiilei		Sequentially list conditions,	b. Due to for a	s a consequence of	۸.							-			
10	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence o	<i>I</i> -										
<u>,</u>	execu n and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of	):							_			
8760,	icate be executed physicien and s the burial-transit	cai		d												
9	rtifica ng ph	Med	d.										53			
Вох	death certifica attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectopic p							te of delive	ery Day Year		
<u>o</u> .	the a	ysic	1 ☐ Yes 2 € No 9 ☐ Unknown	4∐Pregnant : 9□ Unknown	at time of death	5 ☐ Other (sp	pecify)	-						,		
Δ.	The law requires thet the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Ph	Part II. Other significant conditions of	ontributing to death	but not resulting in	the underlying o	ause give	n in Part I.		23e. Did	tobacco	use cont	ribute to th	ne cause of death?		
ds	uires n sign ald be	d by								10	Yes 2	No	3 ☐ Prob	ably 4 Unknown		
of Vital Records,	sw request speed	Completed								24a. Was		24b. \	Were auto	psy findings available		
Re	The la	Eo								auto perfe	opsy ormed? 2001 No	(	prior to cod death? 1 □ Yes	mpletion of cause of 2□ No		
ital	elcien: The law certificete has t irector, page 2 s	BeC	25. Was case referred to medical examiner?					26. Place	of Death	Check only						
Ž	> .97 0	္	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat				4 🗆 Nu	rsing Hom	_^				y)		
Ĕ	ling P	lon;	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D		me of 2 ury M	28c. Injury Work			3d. Des ribe	how inju	iry occurr	red			
Division	or Attending siter death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		njury - At home, fari			′es 2 □ i	-	Rf Location /	Street a	nd Numh	er or Rura	l Route Number,		
Di√	efter Olrect	Certification;	4 Homicide determined	building, e	etc. (Specify)	, 30000, 14000	y, onice			City or To	wn, Stat	е)	or or riare	7. 10410 174111501,		
	To the Hospitel or Attending Ph within 24 hours eiter death. To the Funerel Director: After th completely filled in by the funeral			ysician: To the bes												
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Examone)	niner: On the basis and manner s	of examination and tated.	or investigation	, in my op	inion, deal	th occurred	d at the time,						
	Vith To t	Σ	29b. Signature and title of certifier	1 -	GA D	1	c. License		~					Day, Year)		
				Lune	141.10.		DI:	101	)		J'a	nuas	126	12004		
	5		30. Name and address of person who	1001	death (Item 23a) (T	ype, Print)	6.5	B	altin	nire.	M	aull.	and	21204		
· c	Sta	te	31. Date filed (Month, Day, Year)		trar's Signature							1"				
\$0   100	Registr	- 1	JAN 2 7 2004	100 LOW		1										

			For	State of Man					_	00000
			1 - State Registrar		Cei	rtificate of	Death		Reg. No. ZUUI	+ 030/3
ķ1	Dhysisi		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	Day Year	3. Time of Death
	Physici: /Medic		Leslie Lee	Danie1				Januar		23:45 p <sup>M</sup>
1	Examin		4a. Fecility Name (If not institution, give		. 1		r Location of Death		4c. County of Deal	_
	y.		Prince George Co		spital  n yrs. last birthday)	Cheve 1		8 Date of Birth	Prince G	
j.	Funeral Director		217 03 0313	DM 2DF	1 Yrs. asi birtilday)	Months Days	Hours Min.	8. Date of Birtl (Month, Day Feb. 2,	1912 Nor	hplace (State or Foreign buntry) th Carolina
	pus *		Usual Residence of Decedent  10a. State 10b. County	110	0c. City, Town or Lo	cation				10d. Inside City Limits
	Aaryla f sho	ŏ	Maryland Prince (	'oorgo!a	Seat Plea:	ant				1 ☐ Yes 2 ☐ No
	the the 28a-	rect	10e. Street and Number	eorge 5	eat riea	10f. Zip Code			10g. Citizen of What Co	ountry?
	3a or	0	7320 Joplin Stre	et		20743			United Star	tes
	deatl	Funeral Directo	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	after or ite	正	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give	-	1□Yes 2XNo		, , , , , , ,	Specify: B1a	
8	within 72 hours after death with the Maryland ene. Then "naturel", or items 23a or 28a-f show The Madical Exercine mast be molified at	d by	3 Widowed 4 Divorced	Year or Dates:	16a Daga	dent's Usual Occur	nation		16b. Kind of Business	Industry
7-	n 72 n 72	lete	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retire	during most of work d)	ing	TOD. KING OF DUSTITIOSS	modelity
21215-0036	withi iene r ther	Completed	Elementary/Secondary (0-12) 8th	College (1-4or 5+)	Const	ruction W	lorker		Private	
b	i Hygid other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumame)	
<u>la</u>	should be nd Mentai n marked umatic ev	ToE	Sam Williams				Rhodie	Danie1		
Maryland	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, Its Ma		19a. Informant's Name/Relationship (						or, City or Town, State, 2	
2,	Health tem 27 ther tre		Archie M. Daniel	•		Joplin S		Pleasan Date	t.Md. 20743 20c. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumatic event, If a Medical Examiner nast he notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Hemovai from State	20b. Place of Dispo cemetery, crea		!		1000	
ţ	it. Pa rimen ritant: njury		4 □ Donation 5 □ Other (Specification of Funeral Service Liber of		Metropoli	Ltan Crem	atory 1/1		Alexandria,	Va.
Bal	Department		21. Signature of Pulleral Service Cell	×0.	C COM	Alexande	ess of Facility r S. Pope	Funera	1 Home ville, Md.	207//7
			23a. Part it. Enter the disease, or com	plications that caused th						Approximate
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			RHYTH A			Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	Due to (or as a c		7/1	CKITTI	1 - 3 (		
	Examiner		Conventially list conditions	b						
-	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):					
	eath certificate be executed attending physicien and for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):					
760,	be ex	alE								
687	certificate rding phys use as the			d						
Вох (	nding use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		75			23d. Date of de	livery
	death e atten	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ( 4 Pregnant at tin 9 Unknown		□Ectopic pregnand □ Other (specify) _			Month	Day Year
P.0	by th	hys	9 Unknown					1		
	Se C 0	by	Part II. Other significant conditions of	ontributing to death but i	not resulting in the u	inderlying cause gr	ven in Part I.		obacco use contribute to ∕es 2 □ No 3 □ Pi	20
0.0	w requires been sign should be	Completed				-		24a. Was		
3ec	e la has	E I						autop perfo	rmed?   death?	utopsy findings available completion of cause of
a		ပို	25. Was case referred to medical				26. Place of Deat	1 Yes		2 □ No
₹		o Be	examiner?	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3□ DOA Ot	hor		dence 6 □Other (Spe	cify)
of		⊢-	27. Manner of Death	28a. Date of Injury (Month, Day )	28b. Time o	of 28c. Inju			now injury occurred	
ion	Attending F r death. sctor: After by the funera	atlo	1 Natural 5 Pending 2 Accident investigation	n	ou.) Injury		Yes 2 □No			
Division of Vital Records,	r Atte	Certification:	3 Suicide 6 Could not be determined		- At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
O	urs aff	Cel	20 0 11 11 11 11			th 4 · · · ·		and die a		a data d
	To the Hospitel or Attent within 24 hours after death To the Funeral Director; completely filled in by the	edical		niner: On the basis of example and manner state	xamination and/or in					
	omple	Med	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Moni	h, Day, Year)
			(())		MD	D5	18182		1-12-0	4
) /	(8)		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	, Print)	2.0	0	1-12-6 RLY, MD	0.405
<u> </u>	0/		C/A. C. ST.	GEORGE	3001	HOSPITAL	ŁX	CHEVE	RLY, MD	20785
	Sta Regist	ate	JAN 1 3 2004	32. Registrar	s signature	12				

		4	For State Ragistrar	State of N	Marylan		artment rtificate			and M	lental Hy	giene Reg. No	2001	031	074
	Dhuaiai	Xą.	1. Decedent's Name (First, Middle	, Last)							2. Date of De Month	ath Da	v Year	3. Time of	Death
	Physici /Medic	-	Stanley Ernest								Januar	y 14	, 2004	4:47	ам
	Examin	er	4a. Facility Name (If not institution	_			4b. City, T			of Death			. County of Deat		
- 35	S		Washington Adventure 5. Social Security Number			last birthday)	If Under 1	Year	Park If Under	24 Hrs.	8. Date of Bir	th	ontgome		r Foreian
	Funeral Director		578-40-5731	1 🕅 M 2 🗆 F	70	Yrs.	Months	Days	Hours	Min.	(Month, Da March 2:	y, Year)	933 Wash	hplace (State o nuntry) nington	DC
	2 >		Usual Residence of Decedent  10a, State 10b, County		100 Cit	y, Town or Lo								40d Incide Cit	h. b inside
	shov	5		· Coomool-										10d. Inside Cit	•
,	28a-f	rect	Maryland Prince	e George s	H	yattsv	111e	Code				10a, Ci	tizen of What Co		
12	3a or	Ϊ́	4915 Eastern Av	zenue #104				2078	2				S.A.	,	
į.	ms 2	nera	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13.				gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Ame		
9	or the	E.	1 Never Married 2 Marri	ied 1 X Yes 2 (	□No 195	52_	1 ☐ Yes 2		Specify:	i, i dello	riicari, etc.)		Black, White		
8	/2 hours after death with the Maryland Insturet', or tems 23e or 28e-f show Alcel Executer Lutst be notified at	Completed by Funeral Director	3 Widowed 4 Divorced	Year or Date	s: 1960	100 David	dent's Usual	0				405 1	V	√hite	
र्ग	n /2	jete	15. Decedent (Specify only highes	t grade completed)		(Give	kind of work DO NOT use	done o	during most	t of work	ing	160. K	(ind of Business/	industry	
212	riled within Hygiene. rther than " ent, the Ma	E O	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Sec	urity					Sm	ithsonia	an	
פַ	tal Hyg d othe	BeC	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle	Maider	Sumame)		
<u>yaı</u>	should be nd Mental marked c	2	Samuel A. Davi	S					Ju1i	ia El	lizabet	h Wr	ight		
Maryland 21215-0036	2 sho	19 9	19a. Informant's Name/Relations										or Town, State, 2		
e,	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Indicate it is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Macilcal Exacutes in use in use the notified at once.	10 4	Wendall Davis 20a. Method of Disposition	- Brother	20b. F						Riverd		Maryla: ocation - City or		7
Baltimore,	permit. Pages 1 an Department of Heali Important: If Item 2 any injury or othar 2002e.	h i	1 X Burial 2 Cremation		10	Place of Disposemetery, cres			- 1				ntwood,		
Ħ	artme ortan injury	l i	* 4 □ Donation 5 □ Other (S)  21. Signature of Funeral Service.		FOI								al Home		na
B	Depa impo any is		about	May									11e, MD	•	
	*		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	sed the deat	h. Do not ent	ter the mode	of dying	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Bety	ween
1	nysician	(O )	Immediate Cause (Finaf disease of condition	/ACU	TE	REST	PIRA	TO	MY	E	ALLL	n	£	Onset and D	Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):									
		e.	Sequentially list conditions if any, leading to immediate	b. Due to loc	as a conseq	mence on:	-								
	nsit	i i	cause. Enter Underlying Cause (Disease or injury	EX	TEN	SIVE	PRE	285	UN	E	SOR	2			
ć	te be executed ysicien and se burial-transit	Examin	that initiated events resulting in death) Last	C. Due to (or	as a conseq					-					
8760,	rate be executed thysicien and the burial-transit	cai		d	AL	DETI	25 1	M	ELL	<u>-1 T</u>	US				
89	ing ph as th	Physician/Med	IF FEMALE:									- 1			
Вох	death certifica e attending ph d for use as th	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	2 🗆 Feta	I death 3	Ectopic pre						23d. Date of deli Month		'ear
P.O.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant 9☐ Unknowr		eath 5	Other (spe	cify)							
	iaw requires that the delas been signed by the a 2 should be detached to		Part II. Other significant condition	ens contributing to death	n but not res	ulting in the u	nderlying cau	use give	en in Part I.		23e. Did t	obacco	use contribute to	the cause of d	eath?
Records,	n sign uld be	ed by	DACUTE HYP	ERKALEMI	A,2	ACU.	TE R	Fo	lal fi	ALLU	NE 10'	Yes 2	D√No 3□Pr	obably 4 🗆 U	Inknown
00	ne law require thas been sig ge 2 should b	Completed	3 ACUTE	OCCLU	SIVE	VAS	EULAR	LE	75€	146	24a. Was		24b. Were au	topsy findings a	available
Œ	The I	E	(A) CONON	ARLY AT	TEA	Y DI	SBASA	54	MEN	AIN		irmed?∕ 2 √ No	death?	completion of ca 2□ No	ause oi
/ita	ding Physician: The I h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner?							of Death	(Check only o		<u> </u>		
) to	Physician: rthis certific ral director,	2	1 ☐ Yes 2 ☑ No	Hospital:		ER/Outpatier		1	4 🗀 140	199			6 ☐Other (Spec	cify)	
uc	After funer	ion:	27. Manner of Death 1 Natural 5 ☐ Pendin 2 Accident investig	9	Day Year)	28b. Time o Injury	M 28	C. Injury Work	rat ⟨? /es 2 🗀 l		28d. Describe	now inju	ry occurred		
Division of Vital	or Attending after death. Director: After in by the fune	ertification:	3 Suicide 6 Coufd r	not be 28e. Place of	fnjury - At h	ome, farm, sti			.03 - 2	_			nd Number or Ru	ral Route Numi	ber,
ē	5 # # E	erti	4 Homicide	building,	etc. (Specif	(y)					City or To	vn, State	a)		
) 1a	To the Hospital or Atten within 24 hours after deal To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the be Examiner: On the basis and manner	s of examina	wledge, deat ition and/or in	h occurred at vestigation, i	t the tim	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s date and	) and manner as d place, and due	stated. to the cause(s)	)
	To the Comp	Me	29b. Signature and title of certifier	DA MOV	Me	mms	29c.	License	number	20		29d. Da	te signed (Monti	n, Day, Year)	
)			Machine	EX 13.1.4		A		121	150	13		1	, 14, 0	14.	
			30. Name and address of person			n 23a) (Type.	Print)	33	31-	TO	LEDO	TE	MRAC	£ 1 00	)
			W - 1 = 1	1	far's Sign	and is	<i>y</i> · /	74	TA	CIS	VILL.	C f	MD. 2	076	-
	Sta Regist		JAN 1 6 Z00 (Par)	place .	1										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Lest) 2004 **Physician** 10, JANUARY 4:05 A.M. DAVIS INEZ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY 8. Date of Birth (Month, Day, Jan. 27 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min 1 基M 2 ☐ F Months Days Hours **1**918 Yrs. Jan. 85 Director 224-14-5666 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or itams 23a or 28a-f show the Madical Examiner must be notified at 1X Yes 2 □ No Director Prince George's Capitol Heights Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 United States 1120 Jansen Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If itam 27 is merked other than "natural", or Itan any injury or other traumatic evant, the Madical Evandance and 1 ☐ Yes 2X No 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: altimore, Maryland 21215-0020 Specify: δ Black 3€ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Construction 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fannie Jordan Willie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Capitol Hghts, Md. Mary Virginia Lee/Daughter 1120 Jansen Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1-17-04 Clinton, Md. 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 21. Signature of Funeral Service Liger see 22. Name and Address of Facility Capitol Mortuary, Inc. 20002 1425 Maryland Ave., NE Wash., DC 23a. Part1. Enter the disease, or consheck, or heart failure. List only mplications that caused the death. Deprot enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) ///Edica FATAL CARDIAC ARRHYTHMIA Examiner Due to (or as a consequence of) Examiner HISTORY MYOCARDIAL INFARCTION RECENT ettending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): HYPERTENSIVE HEART DISEASE Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): signed by the e 23b. Did tobecco use contribute to the ceuse of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RENAL INSUFFICIENCY þ 24b. Were autopsy findings available prior to completion of cause of death? certificate has been si irector, page 2 should 24a. Was an autopsy performed? Completed ANEMIA 1 ☐ Yes 2 ☐ No DIABETES MELLITUS 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2X ER/Outpatient 3□ DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 A Natural 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 51520 01-13-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Ave., S.E. Ste. 310 Wash., DC BAHRAM PISHDAD, M.D.

32. Registrar's Signature

Registrar

State

<b>1</b>			For A 2 T. //1	State of N	laryland / De	partment of H	lealth and	Mental Hygi	iene	
		•	1 - For Amend Item#1 Registrar Unpend Ite	l om#23a 27 28a-f	Por ME CROS	ertificate of	Death	Re	19. No. 2004	03076
			Decedent's Name (First, Middle		,1 CT 1111,00020	12/4/04CB		2. Date of Death	h	3. Time of Death
	ysicia	_	DEBORAH DA	AVIS DI	Debo	rah Ann Davi	s	JANUARY	Day Year 16, 2004	5:20 P M
ž.	Medic: camine		4a. Facility Name (If not institution	n, give street and number	r)	4b. City, Town, o	r Location of Deat		4c. County of Deat	
			PRINCE GEORGES	HOSPITAL CI	ENTER	CHEVER	2LY		PRINCE GE	ORGES CO
Fun	eral		5. Social Security Number		Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9. Birth	nplace (State or Foreign untry)
Dire	ctor		577 68 2402	1□M XXXF	52 Yrs.	World Days	Tiodis iviin.			HINGTON, DC
pu »			Usual Residence of Decedent		10c. City, Town or	Location				
larylan	별	_	10a. State 10b. County	/	Toc. City, Town or	Location				10d. Inside City Limits  XIX☐ Yes 2☐ No
M 91 - 88 -1	H	Director		CE GEORGES	CAPITOL					****
ith tt	d a	E C	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
ath w	Tight I	20	320 SHADY GLEN				743		NITED STAT	
ar de tam	Sign of	Funeral	11. Marital Status	12. Was Deceder Armed Forces	5?	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (S an, Mexican, Puer	ipecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
5-0036 72 hours after death with the Maryland naturel; or items 23e or 28e-f show	event, the Medical Examiner must be natified at	by F	XX Never Married 2☐ Mar 3☐ Widowed 4☐ Divorced	If Yes (Street	No	1 ☐ Yes 🏋 No	Specify:		Specify: BL	ACK
21215-0036 and within 72 hours at giene.	Scal E	Completed		nt's Education	16a. De	cedent's Usual Occup	pation during most of wo	rkina 1	6b. Kind of Business/	ndustry
	Ma	nple	Elementary/Secondary (0-12)	College (1-4o	life	. DO NOT use retired	d)	9		
d 21 filed w Hygier ther th	豊	ပ္ပ	12TH			ELF EMPLOY			PRIVATE	
De fil	ue ve	Be	17. Father's Name (First, Middle,				18. Mother's Nar	me (First, Middle, M	faiden Sumame)	
Taryland 2121 2 should be filed within and Mental Hygiene.	atic	၉	MILES DAVIS, SI				MARY BU	JRTON		
Maryland d 2 should be file th and Mental Hy E7 ie marked oth	mag		19a. Informant's Name/Relations			iling Address (Street	and Number or Ru	ural Route Number,	City or Town, State, Z	Tip Code)
⊆ ल •4	ner tr		GLORIA JEAN DAY	VIS / SISTER		SHADY GLEN	N DRIVE		HEIGHTS, M	
			20a. Method of Disposition	3 ☐Removal from Stat	e cemetery, c	position (Name of rematory or other plac	·		20c. Location - City or	Town, State
Pag ment	lury		*4 □Donation 5 □ Other (S	Specify)	LINCOLN	MEMORIAL (		. 26, 04	SUITLAND,	MD
Baltimopermit. Page Department Important: 1	any injury o		21. Signature o Fun al Jervius	Vogese	0 0	22. Name and Addre	ss of Facility S FUNERAT	HOME OF	MARYLAND,	TNC
Ш 202	8 9		1.	1 jaush					ND, MD 20	
A			23a. Part1. Eriter the disease, o shock, of feart failure. List	r complications that caus t only one cause on each	ed the death. Do not e line.	nter the mode of dyin	ng, such as cardiad	or respiratory arre	st,	Approximate Interval Between
Physic			Immediate Carse (Final disease or condition	Narcot	ic Intoxicat:	ion				Onset and Death
/Med	_		resulting in death)	Due to (or a	is a consequence of):					
Exam	Salarie .		Sequentially list conditions,	b						
D	Ħ	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence of):					
8760, sate be executed physician and	the burial-transit	am	that initiated events resulting in death) Last	c	0					
30, se ex	urial	<u> </u>	Togating in dodiny East	Due to (or a	is a consequence of):					
	the	dical		d						
Box 6 death certific	for use as	Me	IF FEMALE:	020 15.000 000000					I	
Box ath cer	or us	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	Ectopic pregnancy	/		23d. Date of deli	very Day Year
_ 0 0	ped (	/slc	1 ☐ Yes 2 ☐ No 9 M Unknown	4∐Pregnant 9□Unknown	at time of death	i ☐ Other (specify)				,
· = >	detached	Physician/Me	Part II. Other significant conditi	iens contribution to doub	but not reculting in the	underhing pause an	on in Dart I	230 Did tob	acco use contribute to	the sauce of death?
S,			Part II. Other significant conditi	ons contributing to death	but not resulting in the	underlying cause giv	enin Fatti.			N/
Orc inper	plnor	ted						1 7 7 9:	s 2 No 3 Pro	obably 4 Nunknown
	2 8	ple						24a. Was an autopsy	24b. Were au prior to c	topsy findings available ompletion of cause of
— <u>= =</u>	page 2	Completed by						perform Yes 2	ed? death?	2 No
Division of Vital F To the Hospital or Attending Physician: Th within 24 hours after decident Aller this certificate	actor,	Be	25. Was case referred to medical examiner?					ath (Check only one	)	
Of \Physic	al dir	၉	1 X Yes 2 No	Hospital: 1  Inpa			4 🗆 Huising i		nce 6 Other (Spec	ufy)
Ing P	uner	Certification:	27. Manner of Death 1 □ Natural 5 □ Penda		Day Year) found	Wor	k?	28d. Describe how	w injury occurred	
Sio	the f	catl	2 Accident investi 3 Suicide 6 CCould	igation 1/16/04 f	ound 4:50	P	Yes 2 No	unknown		
Division  or Attending after death. Director: After	n by	E	4 Homicide determ	mined 288. Place of I	njury - At home, farm, etc. (Specify)	street, factory, office		City or Town,		
ital c	led i			found at						napel Oaks,MD
Hosp 4 hou Fune	ely fi	edical	(Check only 2 2 Medical	ng Physician: To the bes I Examiner: On the basis	of examination and/or					
the the	nplet	Med	one) A	and manner	stated.	29c. Licensi	e number	20	d. Date signed (Month	One Vone
5 iž 5	8	-	29b. Signature and title of certific	- 11	4			29	d. Date signed (Month	( Day, rear)
	İ	ļ	7	/VVI.			ME		JANUARY 17	, 2004
1/2			30. Name and address of person	who completed cause of	death (Item 23a) (Typ				22.0	
Υ			SHEK NI	ווות נטרווין	Name of Singapore	III Pe	nn Stree	t, Baltim	ore, Maryl	and 21201
D.	Stat egistra	_	JAN 2 2 20		strar's Signature	w .				
			J111 0 2 CO	politica	A 1500					
DHMH 17 F	nev 1/20	JU1			ORIGI	NAI				

			For State Registrar	State of	Marylar		artmen			and M	-	giene Reg. No.	200	) 4 0	3077
	Physici /Medi	cal	Decedent's Name (First, Middle, L     NORA KEARNS EFF.	INGER							2. Date of De Month	Day	Ye 2004	ar 4:	ne of Death
	Examir	ner	4a. Facility Name (If not institution, g Genesis Elder  5. Social Security Number 6.	care Th	e Pin	les last birthday)	East If Under	on,	If Under	ylar 24 Hrs.	8. Date of Bir	Ta	Dounty of D. 1bot	Birthplace (St	ate or Foreign
ı	Director		213-09-7242  Usual Residence of Decedent  10a. State 10b. County	1□M 2X F	90	Yrs.	Months	Days	Hours	Min.	JULY T	8 <sup>7</sup> 191	.3	PA	
	the Maryla r 28a-f ehov rotified at	Director		LBOT	Toe. Cit	y, Town or Lo		Code				10a Citiz	en of What	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	le City Limits Yes 2 No
036	within 72 hours after death with the Maryland iene. r then "natural", or Itema 23a or 28a-f ehow the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced	es? X No			ent of Hi	2160 spanic Orig n, Mexican Specify:		ecify Yes or No Rican, etc.)	- 1	4. Race - A	USA merican India /hite, etc.	n,
21215-0036	within jene.	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12) 12	Education rade completed)  College (1-4	or 5+)		dent's Usua kind of wor DO NOT us HOMEM	k done d e retired)	uring most	of workii	ng		d of Busine	ess/Industry	
finger Maryland	be filed stal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Las						18. Mother	RMA	(First, Middle,	Maiden S	iumame)		
Ef.	es 1 and 2 : of Health ar if item 27 le ir other trau		19a. Informant's Name/Relationship  SANDRA E. KLEPPI  20a. Method of Disposition  1 XBurial 2 □ Cremation 3	NGER-Daug	20b. P	1	OX 96	WIT	TMAN,	MD	21676			e, Zip Code) or Town, Stat	•
Nora Baltim	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice	ensee		प्रम∕	. Name and	Address	s of Facility	/ RFTN	-2004 & NEWN ASTON,	AM ET	M T A C T	E, MARY L HOME	
8760,	Physician and phisician and phisician and phisician and the pniial-transit	al Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	ised the death	uence of):	er the mode	of dying	, such as c	eardiac o	r respiratory ar	rest,		Approxi Interval Onset a	mate Between nd Death
P.O. Box 68	siclan: The law requires that the death certificate certificate has been signed by the attending phys rector, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetat It at time of de	death 3	Ectopic pre					23	d. Date of o	delivery Day	Year
ords, P.	equires that hen signed by ould be deta	ρ	Part II. Other significent conditions	contributing to deat	h but not resu	ulting in the un	derlying ca	use giver	n in Part I.				contribute	to the cause Probably 4	of death?
al Reco	n: The law r icate has be r, page 2 sh	Completed	Dementirs								24a. Was a autop perfor	sy med?	death'	autopsy findir o completion o ? es 2 No	gs available of cause of
Division of Vital Records,	To the Hospital or Attending Physiclan: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tlon: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending investigation	Hospital: 1 Inp		ER/Outpatient 28b. Time of Injury		c. Injury	4 Nur	sing Hom	(Check only or te 5 Resid 8d. Describe h	ence 6[		oecify)	
Divisi	vital or Atter urs after dea ral Director lled in by the	Certification;	3 Suicide 6 Could not to determined	28e. Place of building,	, etc. (Specify	()	et, lactory,	office		2	81. Location (S City or Tow	n, State)			umber,
	o the Hosp ithin 24 hou o the Fune ompletely fi	Medical	29a. Certifier (Check only one)  1 Certifying P 2 Medicel Exe 29b. Signature and title of certifier	hysician: To the be miner: On the basi and manner	s or examinat	wledge, death ion and/or inv	estigation,	t the time in my opi	nion, death	place, ar occurre	d at the time, d	ate and pl	ace, and di	as stated. ue to the caus	
	F 3 F 8		30. Name and address of person who	completed cause of	of death (Item	23a) (Tvna F	Н	418	518			1-19	1-Z	004	,
	Sta		31. Date liled (Month, Day, Year)	Sterl	istrar's Signat	50	08	Id	lew	d	Are	En	sten	MD	
	Registr	ar	JAN 2 1 20	U4 Dans	A.	8000									

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 01-LNGERMAN /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner DORCHESTER ANDING If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 1 NM 2□ F Min. Months Deys Hours 21536 2393 Yrs. Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County th and Mental Hygiene. 7 is marked other than "natural", or frems 23a or 28a-f show traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director *WRCHESTER* 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Neyer Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0020 Specify Specify: WHITE Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg. important: if Item 27 is marked other any injury or other traumer. 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Lest) R. HOPKINS 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) RUSSING KOAD, BERLIN, MO 21811 SHARON E. DOSS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State PRESTON, MD 4 ☐ Donation 5 ☐ Other (Specify) HUNDRAL HOME 21. Signatu re of Funeral Service Licenses WILLIAMSON FÜNERAL HOME 311S. MAIN ST. FEDERALSBURG, MO 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Phiracian /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the bunal-transit attending physician and for use as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown ρ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy 1 ☐ Yes 2 ☐ No 1 TYes 2.J. No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification; To Be Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home 5 PResidence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medicai Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

JAN 2 0 2004

completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

29c. License number

788

Drive

29d. Date signed (Month, Pay, Year)

20/04

Suite 5. Easton, MD 21601

			For State Registrar	State of	of Maryland		artment <i>tificate</i>			Mental Hyg	giene 2004	03079
	Physici /Medic Examin	al	Decedent's Name (First, Middle NEIL     A. Facility Name (If not institution	GIVAN	EDGELI	, SR		own, or Lo	cation of De	2. Date of Dea		3. Time of Death 21:05PM
	Funeral Director		5. Social Security Number 221-07-0260	indel  - 6. Sex 171 M 2□F	7. Age (In yrs. I	as <i>t birthd</i> ay) Yrs.	Gle A If Under 1 Months	Year If	Under 24 H lours Mi	MD s. 8. Date of Birth (Month, Day APRIL 2	Anne Ar 2 Year) 2 3,1912 Di	Undel place (State or Foreign intry) ELAWARE
	e Maryland 8e-f show	ctor	Usual Residence of Decedent  10a. State  DELAWARE  SUS	SEX		, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ĀNo
	eath with the 23 or 24 must be no	Funeral Director	10e. Street and Number 24320 GREEN  11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. V	1	973	nic Origin?	(Specify Yes or No-	AMERICA	
9800	within 72 hours after death with the Maryland ene. than "neturel", or Itams 23e or 28e-f show the Medical Exercities mail be codified at	þ	1 ☐ Never Married 2 ☐ Marr 3 🕱 Widowed 4 ☐ Divorced	Armed Fried 1 ☐ Yes If Yes, Gi Year or D	orces? 2 🛣 No		fYes, specii 1□Yes 2	fy Cuban, N	Nexican, Pu	erto Rican, etc.)	Black, White	, etc. HITE
21215-0036	od within 72 k rgiene. ar than "net	Completed	(Specify only higher Elementary/Secondary (0-12) 12		(1-4or 5+)	(Give	dent's Usual kind of work DO NOT use EREC	done durir retired)	R R		LAW FIRM	ndustry
Maryland	should be file nd Mental Hy marked oth imatic event	To Be	17. Father's Name (First, Middle, HERBERT  19a. Informant's Name/Relations	EDGELI		19b. Mailir	ng Address (		IVA	ame (First, Middle, DAVIS  Pural Route Numbe.	Maiden Sumame) r, City or Town, State, 2	ip Code)
	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or items 23a or 28e-f show any injury or other treumatic event, the Medical Exacting must be notified at once.		NEIL G. ED  20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other (S	3 □Removal from	20b. P	lace of Dispo	sition (Name	e of		Date	BURG, MD. 20c. Location - City or GREENWOOD	Town, State
Baltimore,	permit. P Departme Importen any injury		21. Signature of Funeral Service	Licensed (5)	eles		VÄTSC SEAFC	RD,	DELA	WARE 199	HOME, INC	
	Physician /Medical		a. Part1. End this issue, or shoot, or heart failure. List immed to Cause (Final disease of dition resulting in dealth	De	caused the leath each line.  hydro  (or as a consequence)	noit		of dying, s	uch as card	ac or respiratory ari	est,	Approximate Interval Between Onset and Death
8760,	cate be executed by yesician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying area (Lisea of the Arthur Intial Resulting in death) Last	Due to	(or as a consequ	ance of):	tery	Dise	e e			
P.O. Box 68	ath certifi ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live	utcome of pregna birth 2 Fetal nant at time of de nown	death 3	Ectopic pre Other (spe				23d. Date of deli Month	very Day Year
Records, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant condition	ons contributing to o	death but not resu	alting in the u	nderlying ca	use given ii	n Part I.	23e. Did to	bacco use contribute to	the cause of death?
tal Rec	in: The law ifficate has bo	e Completed	25. Was case referred to medica					26	Place of D	24a. Was a autop: perfor 1 Yes	med? prior to death? 2 ☑ No 1 ☐ Yes	opsy findings available ompletion of cause of
on of Vital	To the Hospital or Attanding Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tion; To Be	examiner? 1   Yes 2   No 27. Manner of Death 1   Matural 5   Pendir 2   Accident investi	Hospital: 1 Z 28a. Date (Mon		ER/Outpatier 28b. Time of Injury		Other: lc. Injury at Work?		Home 5 ☐ Resid	ence 6  Other (Specow injury occurred	ify)
Division	ital or Attand irs after death ral Director: /	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 286. Plac	e of Injury - At ho ding, etc. (Specify		eet, factory,	office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical		Examiner: On the and man			vestigation,		on, death oc	curred at the time, o	ause(s) and manner as late and place, and due 29d. Date signed (Month	to the cause(s)
1:	5 M		30. Name and address of person	Juni 1			Print)	027	415	0, 0	BULNIE, M	/
1	Sta Regist		31. Date filed (Month) Day, Year, JAN 2	0 2004 32.	Registrar's Signa		1 11 A	rocks	141	Vr. G/EN	BULNIE, "	10,21061

EDGETT, NEIL

			Please I	State of Mar				-	_	
			For State	State of Mar	•	rtificate of L			g. No. 200L	03080
			Registrar  1. Decedent's Name (First, Middle, Last)			tinoate or E	Journ	2. Date of Deati	1	3. Time of Death
	Physicia	an		scar Emers	on. Jr.			Month January	Day Year 7 19, 2004	
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Dea	ath
	LXaiiiii	Č.	Union Hospital o	f Cecil Co	unty	E1	kton			ecil
	Funeral		5. Social Security Number 6. Sex	144 OF F	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 22	Year) 9. Bi	rthplace (State or Foreign country)
	Director	-	222-26-0476	M 2UF 65	Yrs.			Jan. 22	, 1938 I	Delaware
	land		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Mary Inch	ō	Maryland Ceci	.1		E14	kton			1 ☐ Yes 2 📉 No
	h the	irec	10e. Street and Number			10f. Zip Code		10	og. Citizen of What C	country?
	23a c	Funeral Director	3 Walter Boulden S			219				S.A.
	er des tems	nue	Transaction of the control	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ∐ Yes 2 ∑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. Then "natural", or Items 23a or 28a-f show the Modical Examiner must be notified at	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	ation	na	16b. Kind of Busines:	,
215	thin 7.	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired			2	orporation
7	ed wil	Completed	Six Years		Вос	ly Shop La			ewark, De	laware
nd	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)	monaon Ca			18. Mother's Name		ine Shaha	_
Maryland	d Mer marke matic	ဥ	19a. Informant's Name/Relationship (Ty	Emerson, Si		ng Address (Street)			City or Town, State,	
Ma	d 2 s th an th an traul		Daniel D. Emerson	(son)	-	inding Roa				
<u>ත</u>	s 1 ar f Hea item 2		20a. Method of Disposition		20b. Place of Dispo cemetery, cre				20c. Location - City o	r Town, State
Ę	Page: ent o nt: If ry or		1 🖾 Burial 2 □ Cremation 3 □ F  `4 □ Donation 5 □ Other (Specify)		l	1 Cemeter		3/04 I	ort Depos	it, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or liems 23a or 28a-1 show any injury or other traumatic event. It is Marical Examiner must be notified at angle.		21. Signature of Funeral Service Cicens	99		2. Name and Addres		Son Fund	ral Home.	DΛ
<u> </u>	82589		Thomas M. tat	tenden dr.	P	erryville	Marylan	d 21903	3-0766	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the ne cause on each line	ne death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Acure	RONA	PAILU	RE			7-pms
	/Medical Examiner			Due to (or as a	consequence of):	1				Flore
0		- G	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consednance nt).					7 DAYS
T.	d d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	CEN	GB - TL	INFALL	CTION			5 DAYS
oʻ	e execular and arial-tra		resulting in death) Last	Due to (or as a	consequence of):					
8760,	aath certilicate be executed attending physician and for use as the burial-transit	lical		d		<del></del>				
89 x	entific ding p	Physician/Medi	IF FEMALE:	23c. If yes, outcome of	nregnancy				23d. Date of de	aliven
Вох	death of attended for us	cian	in the past 12 months?	1□Live birth 2 4□Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.O.	the d	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	res that the de signed by the a be detached t	by PI	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	underlying cause giv	en in Part I.			to the cause of death?
ğ	w requires been sign should be				·			1 🗆 Ye	s 2 □ No 3 □ F	Probably 4 XUnknown
မင္ပင	aw 2 st	Completed						24a. Was a autops	v prior to	autopsy findings available completion of cause of
= =	Thate ate	Соп						perform 1 □ Yes 2		s 2 No
Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		at 3 DOA Oth	26. Place of Deat			
o	Phys rthis ral di	5	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c. Injur	y at		ince 6 □Other (Sp iw injury occurred	ecity)
O	Attending Phir death. ector: After this by the funeral	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	Wor M 1□	k? Yes 2 □ No			
Division of Vital Records,	Attendiar death.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	y · At home, farm, st	reet, factory, office		28f. Location (St. City or Town	reet and Number or F	Rural Route Number,
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	To the Hospitel or Attent within 24 hours after death To the Funerel Director. completely filled in by the	edicai	(Check only 2 Medical Exam	rsician: To the best of iner: On the basis of e	examination and/or is	th occurred at the tire restigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
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	F≥Fö		) misml	m- ma	Mr.	D	00 566	21 C	1/19/2	004
			30. Name and address of person who c	ompleted cause of de	ath (Item 25a) (Type	, Print)	- 0		0 - 1	/
	5		MISAEL M. MA	ROLLEZ,	MD 110	W. Ansp	. #320,	WILMIN	D MODED	2 19801
		ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	48				
	Regist	rar	JAN 2 1 2004	A State of the state of	B A	Carlotte St.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2004 Cheryl Christina Eberhardt January 21, 2247 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 2, 194 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🂢 F 215-40-1236 59 Yrs. Director Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Mode is 1 end 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
Item 27 is marked other then "naturel", or Items 23a or 28e-1 show other treumatic event. It would be a continuated to will be a continuated to a continuated to a continuated and a Maryland Harford Havre de Grace 1 ☑ Yes 2 ☐ No Directo 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 135 Bloomsbury Avenue 21078 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 🌂 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Havre de Grace Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Instructional Assistant Twelve Years Havre de Grace, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard M. Blevins Hazel I. Reedy permit. Pages 1 end 2.
Department of Health an.
Important: If item 27 is m.
eny injury or other. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Eberhardt 135 Bloomsbury Avenue, Havre de Grace, MD 21078 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 □ Donation 5 □ Other (Specify) Harford Memorial Gardens 01/26/04 Aberdeen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas M. Latterson, Dr. Lee A. Patterson & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Car cirona **Physician** /Medical Due to (or as a consequence of) **Examiner** Carcinoona Metastatic Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Metas Tatic Records, P.O. Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe [ borting Kraner 1 ☐ Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funerel C 1. \*\* Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and little of rtifier 29d. Date signed (Month, Day, Year) D-15994 www 1-22-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S, UNION AVE HAURE DEGRACE GALVEZ LETICIA S. M.D. 625 MD 21078 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 3 2004 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 9, 2004 Enrique Ventenilla Estrada January 10:30 pm /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gladys Spellman Nursing Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 2, 7. Age (In yrs. lest birthday) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 1 M M 2 ☐ F Funeral Days Hours Months Philippines 88 Director 562-54-0020 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 ¥ Yes 2 □ No Director Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20737 5707 Longfellow Street U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: KOREAN Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No Specify: Specify: Be Completed by Asian 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dental Specialist U.S. Army 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Noberto Estrada Filomena Ventenilla 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Demetria G. Estrada - Wife 5707 Longfellow Street, Riverdale, MD 20737 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Buriel 2 □ Cremetion 3 □ Removal from State 1/23/2004 Arlington, Virginia Arlington National Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral S ice Licensee 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical e Cerebral Anoxia Examiner Due to (or es a consequence of) Physician/Medical Examiner Pneumonia or Attanding Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events Due to (or as e consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Congestive Heart Failure Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 📉 No Medical Certification: To 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Naturel s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) (Check only one) end manner stated. 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature end title of certifier D50862 JANUARY, 10, 2004 Sprif Harun MO 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 9831 Greenbelt Road, #103, Greenbelt, Maryland 20770 Sherif Hassan, MD

Registrar DHMH 16 Rev 6/95

Month, Day, Year) AN 1 4 2004

32. Registrer's Signature

			For State Registrar		State o	of Ma	ryland		rtment			and M	ental Hyg	giene leg. No. 2 (	004	030	083
	Physicia		1. Decedent's Name (First					-					2. Date of Dea Month	ry 13,2	Year	3. Time of	
	/Medic	-		eth Eat									Janua	4c. County		3:45	A.M
	Examin	er	4a. Facility Name (If not in Manor Care			im <i>ber)</i>			•	:hesd	Location o la	Deam			gome	сy	
	Funeral		5. Social Security Number			7. Age	(In yrs. la	ast birthday)	If Under	1 Year	If Under		8. Date of Birth	Vear	9. Birth	place (State o	r Foreign
	Director		579-28-2508	1	M 2[3€F		91	Yrs.	Months	Days	Hours	Min.	Sept. I	0,1912	Nori	olace (State on http) Caro	olina
	p a		Usual Residence of Deceded 10a. State 10b.	dent County			10c. City.	, Town or Lo	cation							10d. Inside Ci	ty Limits
	Maryla f sho	ō		ntgomer	У		-	thesda								1X Yes	2 🗆 No
	28a-	Director	10e. Street and Number						10f. Zip	Code				10g. Citizen of	What Cou	ntry?	
	h with	ai D	6530 Democ	racy Bl	_vd				20	817					USA	A	
	ems 2	Funerai	11. Marital Status		12. Was Ded Armed F	edent E	ver in U.S	S. 13. \	Vas Deced Yes, spec	ent of His	spanic Ori n, Mexicar	gin? (Spe	cify Yes or No- Rican, etc.)	14. Rac Bla	ce - Ameri ck, White,	can Indian, etc.	
9	within 72 hours after death with the Maryland ene. Itan "natural", or Items 23a or 28a-f show he M. dical Examiner must be notified at	by Ft	1 ☐ Never Married 2 3 🖾 Widowed 4 ☐ D		1 ☐ Yes if Yes, G Year or [	ive	0		∏ Yes 2	No 🎦	Specify:			Specil	y: Bla	ack	
3	hour stural	ed t		ecedent's Edu			1	16a. Deced	ient's Usua	il Occupa	tion			16b. Kind of B			
212	hin 72	piet		ly highest grad (0-12)	completed)		+)	life.	kind of wor DO NOT us	e retired)	uring mos	t of worki	ng				
7	ad wit	Completed	Elementary/Secondary					Home	Make	er			(50)	Priva			
nd	be file	Be	17. Father's Name (First,										e (First, Middle, Finch	Maiden Sumai	719 <i>)</i>		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene.  I amelied the than "natural", or lieuns 23a or 28a-f show termatic event, the Marylan Examiner mant by notified at	L <sub>O</sub>	Zed Finch		ne Print)			19b. Mailir	na Address	(Street a			I Route Numbe	r. City or Town	State, Zij	code)	
	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		Carla River						•				rmantow			,	
ē,	of Health of Health fitem 27 r other tr		20a. Method of Dispositio				20b. Pl	ace of Dispo	sition (Nan	ne of ther place	9)		Date	20c. Location	-	own, State	
Ē	Pages nent of ant: If it ury or o		1X Burial 2 ☐ Crei 14 ☐ Donation 5 ☐ C		emovai from	State		yland	Natio	ona1	1	/17/	04	Laurel,	MD		
Baltimore,	permit. Pages Department of Importent: if it any injury or o		21. Signature of Funeral	Service Licens	Del	ím.	76	7 38	. Name an			_	atney's W, Wash				С
塩			23a. Part1. Enter the disc shock, or heart failu	ease, or compl ire. List only o	ications that ne cause on	caused each line	the death e.	. Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory ar	rest,		Approximat Interval Bet Onset and	ween
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	/Medical Examiner		, occurry		Due to	(or as a	consequ	ience of):									
	78	Jer	Sequentially list condition if any, leading to immedia cause. Enter Underlying	ns, ate	Due to	(or as a	consequ	ence of):									
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760,	icate be executed physician and s the burial-transit	cal Ex	resulting in death) cast	ı	Due to	orasa	consequ	ience ot):									
	physics the t	edica			d											-	
ŏ.	n certil	Z/M	IF FEMALE: 23b. Was decedent preg	nant	23c. If yes, or		of pregnal		∃Ectopic pr	egnancy					ate of deliv	-	
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٣.	that the	y Ph	Part II. Other significant	conditions co	ntributing to	death bu	it not resu	ulting in the u	nderlying c	ause give	en in Part I	l.	23e. Did to	obacco use cor	tribute to	the cause of	death?
rds	w requires that been signed E should be deta	ed by							_				101	res 2. ☐¥No	3 🗌 Pro	bably 4 □	Unknown
Vital Records,	ne law re has bee ge 2 sho	Completed											24a. Was	SV	prior to co	opsy findings	available ause of
œ —		Com											perfo 1 ☐ Yes	rmed? 2 🔯 No	death? 1 🔲 Yes	2 🗆 No	
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to examiner?	100	Hospital:					Othe	Ar:		h (Check only o				
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)	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical Ce	29a. Certifier 1 🔀	Certifying Phy Medical Exam	iner: On the	ne best of basis of	examinat	wledge, deat tion and/or in	h occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and m	anner as	stated. to the cause(s	s)
3	o the o the o the	Med	29b. Signature and title of	of certifier	gritt fild				290	c. License	e number			29d. Date sign	ed (Month	, Day, Year)	
	r ≥ ⊢ ŏ		· 7	11 1	no 1/2	- pri	5 , 6	no		Do	05	7/	24	11114	1/00	4	
			30. Name and address o	f person who c	ompleted car	use of de	eath (Item	23a) (Type.	Print)				own, MI			1	
			31. Date filed (Month, Da				ar's Signa				,						
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Baltimore, Maryland 21215-0036

	1 - For State Registrar	Glate UI	iviai ylailu		rtificate of	lealth and N			7 11 11	4 0308
	Registrar  1. Decedent's Name (First, Middle.)	. Last)	<u></u>		tineate of	Deatri	2. Date of De	Reg. No	. = 0	3. Time of Death
n	Wendell	Deweese	Flamer				JANUAI	RY 15	2004	8:20 p
l r	4a. Facility Name (If not institution,	give street and numb	ber)	A DIC	4b. City, Town, o	or Location of Death		4c.	. County of D	eeth
ı	NEAR INTERSECTI				If Under 1 Year	If Under 24 Hrs.	B Date of Bi		ORCHES	
	5. Social Security Number 217–44–1123	6. Sex 7. 1 22 M 2 ☐ F	. Age <i>(In yrs. last</i> 57	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da July 1	4,19	946	Birthplace <i>(Stat</i> e o <i>r For</i> e <i>Country)</i> Maryland
	Usuel Residence of Decedent  10a, State 10b, County		10c. City, T	Four or Lo	postico					10d. Inside City Lim
	,		100.04, 1							1 ☐ Yes 2 💯
	Maryland Carol  10e. Street and Number	ine		Fede	ralsburg			10a. Cit	tizen of What	Country?
	3676 Houston	Branch Boa	ı d		216	32			JSA	
	11. Marital Status	12. Was Deced	ent Ever in U.S.	13.	Was Decedent of F	Hispanic Origin? (SI	pecify Yes or No		14. Race - A	merican Indian,
	1 Never Married 2 Marri	Armed Force 1 Tes 2 If Yes, Give	! <b>™</b> No		If Yes, specify Cub 1 ☐ Yes 222 No	an, Mexican, Puerti Specify:	o Hican, etc.)		Black, W	hite, etc.
•	3 ☐ Widowed 4 ② Divorced	Year or Dat	es:		1 192 ZINO	эрөспу.			Specify:	Black
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nandillon a	Elementary/Secondary (0-12)	College (1-4	4or 5+)		<i>DO NOT u</i> se retire: er Operat	,		Kr:	aft Fo	ods
	17. Father's Name (First, Middle, I	ast)		TITAL	- Sperac	18. Mother's Nan	ne (First, Middle	1		
	Bascom	Flamer				Hilda	Tur	cpin		
	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City o	or Town, State	e, Zip Code) 21632
	Brent Rickett	s / Son		367	76 Housto	n Branch	Road, 1	Feder	ralsbu	rg,Maryland
	20a. Method of Disposition		com	e of Dispo	sition (Name of matory or other pla		Date			or Town, State
	1   Burial 2 □ Cremation  1 □ Donation 5 □ Other (Sp		1210	-		1				
- 1				ina (	Prove Cem	101/2	2/2004	Den	ton Ma	rvland
	21. Signature of Funeral Secrice I	icensee	- Spr	-	Grove Cent  2. Name and Addre	ess of Facility	2/2004		ton,Ma	•
	21. Signature of Funeral Secret	icensee	Spr	-	2. Name and Addre	ess of Facility				•
	23a. Part1, Enter the disease, or	complications that cau	used the death.	> 22	Name and Address Sennie S 426 Dove	ess of Facility Smith Funder Street	eral Hor , Eastor	ne n,Ma		21601 Approximate
	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that cau	used the death.	Do not ent	2. Name and Addre Bennie S 426 Dove er the mode of dyin	ess of Facility Smith Funder Street or Street	eral Hor , Eastor	ne n,Ma		21601
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To the Hospital within 24 hours a To the Funeral I completely filled

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) JAN 20 State Registrar

29b. Signature and title of certifier

strar's Signature

29c. License number OCME

29d. Date signed (Month, Day, Year) JANUARY 16,2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Frederick Day Year lanche January 15,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Memorial Dakland County Hos pital Garret 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, july 11 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Hours 1 ☐ M 2 1 F 579-42-4435 **Director** NY Usuai Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show 10d. Inside City Limits the Medical Examinar must be notified at Director 1 XYes 2 □ No MONTGOMERY MD SPENCERVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? UNKNOWN 20868 USA filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 M Divorced WHITE "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME other injury or other traumatic event, permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any lury or other traumatic event once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN GREGORY MILDRED 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIEL FREDERICK - SON 6443 BARRIE DEARBORN, MI 48126 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) OMEGA CREMATORY 1/22/04 MORGANTOWN, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardiovascular **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetel dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 25 No ours after death. neraf Director: After this certifica filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

alter 31. Date filed (Month, Day, Year)

JAN 2

0

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

Vaumann

		•	For State Registrar	State of Ma	aryland /	•	artment of He rtificate of D			iene <sub>9g. No.</sub> 20 (	) 4	03086
			1. Decedent's Name (First, Middle, Las	t)					2. Date of Deat Month	_	ear	3. Time of Death
	Physicia /Medic			MILDRED	OPAL FI	TZW	ATER		JANUARY			1:35 P.M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death		4c. County of	Death	
			GARRETT COUNTY ME	MORIAL HO	SPITAL		OAKLAND			GARR		
	Funeral Director		5. Social Security Number 6. Se	7. Ag	e (In yrs. last b 97	oirthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV . 2	γ <sub>θαr)</sub> 7, 1906	. Birthpl Coun MD	ace (State or Foreign try)
-	ס		Usual Residence of Decedent				· · · · · ·					
	rylan		10a. State 10b. County		10c. City, To	wn or Lo	ecation				10	0d. Inside City Limits
	ta-f a	Director	MD GARRETT		SWAN	NOT						1 ☐ Yes 2 🗖 No
	or 28	Dire	10e. Street and Number				10f. Zip Code		11	0g. Citizen of Wh	at Coun	try?
	ath w	ē	2714 BITTINGER R					1561		USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner; ust be multified at once.	y Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1  Yes 2 Y			Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☐ No	spanic Origin? (Spanic Origin? (Spanic Origin?) Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	White,	etc.
21215-0036	hours tural	Completed by	3 Widowed 4 Divorced	Year or Dates:	16	a Dece	dent's Usual Occupa	tion		16b. Kind of Busin		LTE
5	"nai	ete	15. Decedent's Ed (Specify only highest grad	de completed)		(Give	kind of work dorre di DO NOT use retired)	uririg most of worki	ing	TOD. KING OF DUSI	1022/11/	adstry
7	withi ene. than	E C	Elementary/Secondary (0-12)	College (1-4or 5	i+)		HOMEMAKER			OWN HO	ME	
	filled Hygi sther	Ö	17. Father's Name (First, Middle, Last)					18. Mother's Name	e (First, Middle, M			
an	ld be ental ked c	ToB	ALBERT LUTHE	ER RILEY				ROSE JAN	NE BERNA	RD		
Maryland	shoul nd M mari	<b>-</b>	19a. Informant's Name/Relationship (7		19	b. Maili	ng Address (Street a	nd Number or Rura	al Route Number,	City or Town, St.	ate, Zip	Code)
	nd 2 Ilth al 27 is r trau		EILEEN CUSTER-DA	UGHTER		1588	BITTINGE	R ROAD, S	WANTON,	MD 215	61	
ē,	s 1 ar	1 3	20a. Method of Disposition		20b. Place	of Dispo	sition (Name of matory or other place	1 0		20c. Location - Ci	ty or To	wn, State
5	ages ant of nt: If i		1 MBurial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify			-	L CEMETER		19/04	SWANTON,	MAR	YI.AND
Baltimore,	permit. F Departme Importar any injur	1	21. Signature of Juneral Service Licen		- 1002	22	2. Name and Address	s of Facility				21550
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Н			shock, or heart failure. List only of	one cause on each li	ne.	J HOL OIL	er the mode of dying	, such as cardiac (	or respiratory arre	331,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. acuil	L myo	care	leal info	urt			- 3	36 hr
н	/Medical Examiner		rosuling in douting	Due to (or as	a consequenc	e of):	- 1					, 0
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	and and II-trar	Examin	that initiated events resulting in death) Last	c. Due to for as	a consequence	ALL e of):	7U		·		-   -	years
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.O. Box (	ne death certifica the attending planed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetel dea		Ectopic pregnancy Other (specify)			23d. Date of Month		ry Day Year
۵.	s that the de ned by the a detached f	by Ph	Part II. Other significant conditions of	ontributing to death b	ut not resulting	in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contrib	ute to th	e cause of death?
rds	quires n sign uld be								1 □ Ye	is 2 No 3	☐ Prob	ably 4 Unknown
Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed							24a. Was as autops perform	ned?   dea	ith?	osy findings available npletion of cause of 2 No
tal		0	25. Was case referred to medical					26. Place of Deatl				
<u>=</u>	Physician: this certitic ral director,	.o B	examiner? 1 Yes 2 No	Hospital:	ent 2 EPV	Dutpatie	nt 3 DOA Othe	r: 4 🗆 Nursing Ho	me 5 🗆 Reside	nce 6 Other	(Specify	')
on of	Jing P. Atter funel	tion; T	27. Manner of De th 11 Natural 5 Pending	28a. D te of Inju (Month, Da	y Year) 28b	. Time o	Work			w injury occurred		
Division	l or Attending after death. Director: Atte I in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, c. (Specify)	farm, st	reet, factory, office		28f. Location (St. City or Town	reet and Number n, State)	or Rura	l Route Number,
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely tilled in by	edical C		ysician: To the best niner: On the basis o and manner st	f examination a							
	To the vithin To the outle	Me	29b. Signature and title of certifier	: /			29c. License	number	25	9d. Date signed (	Month, i	Day, Year)
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	10		30. Name and address of person who	completed cause of c	leath (Item 23a	ı) (Type.	Print)					
	4		margaget KAISE		13079	60	Print)	hwas	Oaks	and 1	Id	21550
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		0	/				
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		•	1 - State Registrar		Certificate of		Reg. N	4004	00007
	Physici		1. Decedent's Name (First, Middle, Las	0	·		Date of Death     Month     D	ay Yeer	3. Time of Death
	Physici: /Medic		Goldie		ickinger		January.	12,2004	1645 M
	Examin	er	4e. Fecility Name (If not institution, give			or Location of Death	r	Nontgon	00.01/
	Funeval		5. Social Security Number 6. Se	Adventist Ho	last birthday) If Under 1 Yea		8. Date of Birth	9. Birth	place (State or Foreign
	Funeral Director			□M 2X F 96	Yrs. Months Day	s Hours Min.	8. Date of Birth (Month Day, Yea Aug. 22, 1	907 Peni	nsylvania
	D >		Usual Residence of Decedent  10a. State 10b. County	10c Cit	ty, Town or Location				10d. Inside City Limits
	fanyla	o	Md. Montgo		Rockvill	.e			1 XYes 2 No
	28a-1	rect	10e. Street and Number		10f, Zip Code	,	10g. C	Citizen of What Cou	ntry?
	within 72 hours after death with the Maryland ene. Than "natural", or items 23e or 28e-f show he Miscigal Exprimer main be multised at	Completed by Funeral Director	9701- Veirs	Drive	2	20850		USA	
	death ms 2	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was Decedent of	f Hispanic Origin? (Speuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	or it	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ <b>X</b> No If Yes, Give	1 ☐ Yes 2 🔀 N			Specify: Wh:	
Ö	hours tural	q pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a Decedent's Usual Occ	upation	16b.	Kind of Business/Ir	dustry
15	nin 72 n ne	piet	(Specify only highest gra	de completed)  College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	ne during most of working red)			
21215-0036	filed with Hygiene Ither tha	Com	10		Homemake			t Home	
	be filed tal Hygi d other event, t	Be	17. Father's Name (First, Middle, Last) Addison A. H				(First, Middle, Maide Grace Re		
Maryland	should be tind Mental I	٩	19a. Informant's Name/Relationship		19b. Mailing Address (Stre				Codel
Ma	od 2 sho lith and 27 is m		Harry Flicking		8730-Locha				
re,	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Modical Examiner mast be notified at	- 13	20a. Method of Disposition	20b. F	Place of Disposition (Name of cometery, crematory or other p	place)		Location - City or T	
Baltimore,	permit. Page Department o Important: If any injury or ance:		1 XBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	M+	.Olivet Ceme	etery 1/16	5/2004 Ha	anover,	Pa.
Balt	permit. Pag Department Important: Imy injury c		21. Signature of Funeral Service Licen		22. Name and Add Hysong	ress of Facility Co., Inc.			
			23a. Part1. Enter the disease, or cimi	plical ons hat caused the deat one susy on each line.	th. Do not enter the mode of d	th St., NV	V, Washii	ngton, Do	Approximate
			Immediate Cause (Final	A	1				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq					3 days
	Examiner		Sequentially list conditions	b. Sepsis					3 days
100	B #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	quence of):				0
	xecut and al-tran	xarr	that initiated events resulting in death) Last	cDue to (or as a conseq	quence of);				
760,	eath certificate be executed attending physician and for use as the buriat-transit	calE		d					
68	certificate nding phy use as the	ledic							
Вох	th cer lendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		ncy		23d. Date of deliv	ery Day Year
	the atten the atten hed for u	by Physician/Medi	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4□Pregnant at time of o 9□Unknown	death 5 Other (specify)			WOILL	Day
P.0	w requires that the de been signed by the s should be detached	Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying cause	given in Part I.	23e. Did tobacco	o use contribute to	he cause of death?
Division of Vital Records,	requires een sign						1 ☐ Yes	2□No 3□Pro	bably 4 Dunknown
CO	law req as beer 2 shou	Completed					24a. Was an	24b. Were aut	opsy findings available
Re	0 - 0	omp					autopsy performed? 1 ☐ Yes 2 2 4	death?	ompletion of cause of 2□ No
ital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death			
of V	dis d	2	1 ☐ Yes 2 ᡮ No		ENOutpatient 3 DOA	and the same of th	ne 5 Residence		fy)
ou c	ling After fune	tlon:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time ol 28c. In Injury M 1	ljury at Vork? □ Yes 2 □ No	8d. Describe how inj	jury occurred	
/isi	al or Attending s after death. I Director: After d in by the fune	fical	3 ☐ Suicide 6 ☐ Could not be	9 28e. Place of Injury - At h	ome, larm, street, lactory, offic		81. Location (Street		al Route Number,
Ö	spital or Atten ours after deat teral Director: filled in by the	Certification:	4  Homicide	building, etc. (Specia	<i>īy)</i>		City or Town, Sta	110)	
	a Hospital or Attence 24 hours after death Funeral Director: etely filled in by the	edical	(Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina					
	를 를 를 들	Medi	one)  29b. Signature and title of certifier	and manner stated.		ense number		Date signed (Month,	
	To with		I South	2 41 5		1	lane .		
0	(2)		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	70757	Jan	uary 12	12004
1	9		Leo Shue	1901 Medica	1 Center Di	:ve Ro	ckville, 1	naryland	20850
	Sta Regist		31. Date liled (Month, Day, Year)  JAN 1 4 2004	32. Registrar's Signa	ature			ę	

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar	State of Marylan		artment of H rtificate of L		F	Reg. No.	004	030	088
	Physicia		Decedent's Name (First, Middle, Last,     JOSEPH	FRA <b>S</b> ER				2. Date of Dea Month	Day	00 4 Year	3. Time of 12:28	
	/Medic	al -	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deal	th		nty of Death	12.20	
	Examin	er	HOLY CROSS HO			SILVER			MON	TGOMER	Y	
	Funeral Director		136-18-0269	x 7. Age ( <i>In yr</i> s. 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h y, Year) 1919	Cour	olace (State of otry) h Carc	-
	rland ow	-	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside Cit	•
	e Man le-f sh	ctor	MD PRINCE GE	EORGE'S SU	ITLANI						1X Yes	2   No
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code 20746			U.S.		ntry?	
	ns 23e	eral	3208 SWANN ROAD  11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No		Race - Americ		
920	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28e-f show he Madical Examinar must be notified at	þ	1 Never Married	Amed Forces? 1 ∐Yes 2∭No If Yes, Give Year or Dates:			n, Mexican, Puer Specity:	to Hican, etc.)		Black, White, sc <i>ify:</i> BI	etc. ACK	
21215-0036	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occupa	durina most of wo	orking	16b. Kind o	f Business/In	dustry	
121	within ane.	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired WELDER	1)		PRIV	ATE		
Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or Items 23a or 28e-f show appringury or other treumatic event, the Medical Examinating must be nyilling at Once.	Be	12   17. Father's Name (First, Middle, Last) WALTER FRASER				18. Mother's Na ELIZABE	me <i>(First, Middl</i> e, TH HARM	Maiden Sun ON	пате)		
ary	should and Me s mark umati	욘	19a. Informant's Name/Relationship (T	ype, Print)		ng Address (Street					Code)	
Σ	and 2 ealth a n 27 is		PAULINE FRASER/W			SWANN RD	. SUITLA	ND, MARY			State	
Baltimore,	ges 1 if of Ho if iter		20a. Method of Disposition 1 ☼ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	osition (Name of matory or other place				on - City or To		
Ħ	ift. Pa intmen ortant: injury b.		*4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service License			TION CEME  2. Name and Addres	The state of the s	4-2004 B. JENK			RYLAND HOME	
Ba	Depar Impor eny ir		) / L B	-		7474 LAND						5
	ate be executed // Medical Examiner transit the burial-transit	Examiner	shock, or heart failure. List only of disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Chronic ( Due to (or as a consect b. Hypertens Due to (or as a consect	quence of): Sion quence of): Lve Pul	nyopathy Lmonary D:	isease				Interval Bett Onset and E	
.O. Box 68760,	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	al death 3	Ectopic pregnancy Other (specify)	1		23d.	Date of delive		Year
s, D	es that igned l	by P	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the	underlying cause giv	en in Part I.		obacco use d Yes 2□N		he cause of d	death? Unknown
Records,	aw requir 1s been s 2 should	Completed						24a. Was autop	an 24 osy ormed?	lb. Were auto prior to co death?	opsy findings impletion of c	2 =
Vital		O	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath (Check only o	2X No	1 🗆 Yes	ZIXI NO	
Ţ	ysici	To B	examiner? 1 ☐ Yes 2 E No	Hospital: XXInpatient 2	] ER/Outpatie		4 Li Nuising	Home 5 ☐ Resi	dence 6 🗆	Other (Speci	fy)	
ion of	ing Afte une	1 1	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time Injury	Wor	yat k? Yes 2∐No	28d. Describe				
Division	P ife	Certification;	3 🗍 Suicide 6 🗎 Could not be 4 🗍 Homicide determined	28e. Place of Injury - At h building, etc. (Spec		treet, factory, office		28f. Location ( City or To		umber or Rur	al Route Num	iber,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exan	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, dea ation and/or i	th occurred at the tir nvestigation, in my o	me, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and date and pla	I manner as s ce, and due t	stated. o the cause(s	;)
	To the Ivilian 24	Med	29b. Signature and title of certifier	4		29c. Licens	e number			gned (Month,	Day, Year)	
			* Kobert to	ward MD		D55	5522		1-10-2	004		
R	-(10)		30. Name and address of person who Robert H. Gerrard		m 23a) (Type Forest	Glen Road	l Silver	Spring,	Mary1	and 20	910	
	St Regist	ate trar	31. Date filed (Month, Day, Year)  JAN 1 4 2004	32. Registrar's Sign	ature	K)						

			For State Registrar	State of Maryland /	Department of Health Certificate of Deat	h	ene 2004 03089
	Physici	an	1. Decedent's Name (First, Middle, L	ast)	)	2. Date of Death Month	Day Year
	/Medic Examir	7 1844	4a. Fecility Name (If not institution, gr	ve street and number)	4b. City, Town, or Location	n of Death	4c. County of Death
	Funeral Dírector		217-50-2372	QUARE HOSPITA Sex 7. Age (Infyrs. last)	hirthday) If Under 1 Year If Under 1 Year Months Days Hour	ler 24 Hrs. 8. Date of Birth (Month, Day,	PA TIMORE  9. Birthplace (State or Foreign Country)  1947 Mary and
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location		10d. Inside City Limits
	n the Maryland r 28a-f show	Director	md harF	ord Abe	rdeen	140	V Yes 2 No
	th with the 23s or 2 ust be a	i Dir	10e. Street and Number	an Alle	10f. Zip Code 21001	10	g. Citizen of What Country?
36	s after dea , or Items	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No If Yes, Give/ Year or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexic	can, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-00	72 hour natural	eted	15. Decedent's l	Education 16	Sa. Decedent's Usual Occupation (Give kind of work done during m	ost of working	6b. Kind of Business/Industry
21215-0036	C * 66	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)  Homemaker		Home
Maryland 2		To Be C	17. Father's Name (First, Middle, Las	Nessenger		ther's Name (First, Middle, M.	aiden Sumame)
Man	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a Informant's Na e/Relationship	(Type, Print) 1	9b. Mailing Address (Street and Nun	A	. A N
			20a. Method of Disposition	come	of Disposition (Name of tery, crematory or other place)	Date 2	Oc. Location - City or Town, State
Baltimore,	nit. Page vartment o ortent: If injury or		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	city) Cokes	bury Cemetery	1-24-04	Abing don, Md
Bal	permit. Departi		21. Signature of Funeral Service Lic	w. Ilnglesbe	P 333 Suth	Parke St.	Aberdeen Md21161
		3	shock, or heart failure. List on	mplications that caused the death. D	o not enter the mode of dying, such	as cardiac or respiratory arres	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Uterine  Due to (or as a consequence	avcer		
	Examiner	Ļ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	o of):		
	uted d ansit	Examiner	rany, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	C C	æ orj.		
8760,	cate be executed physician and the burial-transit	ai Exa	resulting in death) Last	Due to (or as a consequence	e of):		
9	phy:	ledical		d			
P.O. Box	Attending Physician: The law requires that the death certif refeath. ector: Atter this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown			23d. Date of delivery Month Day Year
	es that tigned by	by Ph	Part II. Other significant conditions	contributing to death but not resulting	g in the underlying cause given in Pa	rt I. 23e. Did toba	acco use contribute to the cause of death?
ord	w require been signatured should b	eted				1 🗆 Yes	
Rec	The law te has l age 2 s	Completed				24a. Was an autopsy perform	prior to completion of cause of
/ital	ysician: The l is certificate he director, page	Be	25. Was case referred to medical examiner?	Hospital:		ace of Death (Check only one	/ -
Division of Vital Records,	g Physi er this c eral dire	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Sunpatient 2 EHV	. Time of 28c. Injury at	Nursing Home 5 Resident 28d. Describe how	
sion	tending I leath. tor: After the funer	catio	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	on	M 1 ☐ Yes 2		
Divi	el or Attendi s after death il Director: A	Certification:	4 Homicide determine	d 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	City or Town,	eet and Number or Rural Route Number, State)
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier Check only one) Check only	Physician: To the best of my knowled aminer: On the basis of examination and manner stated.	ige, death occurred at the time, date and/or investigation, in my opinion, o	and place, and due to the cau death occurred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within 2 To the Complet	Mec	29b. Signatur and itle of certifier	0 01	29c. License numbe		d. Date signed (Month, Day, Year)
			portaria	- Salar, M	1.D. D00604	153 5	anuary 20 2004
	5		30. Name and address of person wh	o completed cause of death (Item 23)	a) (Type, Print) F	ALE DE BA	anuary 20 2004
I	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature			

DHMH 17 Rev 1/2001

ORIGINAL

		,	1 - For State Registrar	State of Maryland	d / Depa		lealth and	Mental Hy	giene	2001	+ 03	3090
	Physici /Medic			Mc Guiga	Ν			2. Date of De Month	2 Day	04	5	of Death
Sept.	Examin	er	4a. Fecility Name (If not institution, give s  STELLA MARTS HOSP:  5. Social Security Number  6. Sex	TCE 7. Age (In yrs. I	ast birthday) Yrs.	4b. City, Town, o  TIMOI  If Under 1 Year  Months Days		s. 8. Date of Bi	rth	BALTIMO  9. Birt	RE hplace (Stete	or Foreign
	Director Months of the Control of th	or	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo			OCTOBE	ж Z,	1914 P	10d. Inside	
	with the N a or 28a-f be could	Director	PENNSYLVANIA MONTO  10e. Street and Number  432 OLD FARM ROAD	GOMERY	WYNCC	10f. Zip Code 1909			_	zen of What Co		
136	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show eny figury or other traumatic event, the Medical Examinar miss be notified at once.	by Funeral		12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes, 2√2 No If Yes, Give A Year or Dates:	1	Was Decedent of Hilf Yes, specify Cuba		(Specify Yes or Narto Rican, etc.)		14. Race - Ame Black, Whit	rican Indian,	
Maryland 21215-0036	i within 72 hou pene. r than "nature the Medicul	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life.	dent's Usual Decup kind of work done DO NOT use retired ECRETARY	during most of w	orking		nd of Business		).
/land	uld be filed a Mental Hygie irked other itic event, it	To Be C	17. Father's Name (First, Middle, Last) WILLIAM FLOREY					ame (First, Middle UDE GREA		Sumame)		
	and 2 should ealth and Men n 27 ie marke		19a. Informant's Name/Relationship (Typ. JOSEPH H. FLOREY/BI	ROTHER	351	ng Address (Street FARM LANI		WALES,	PA	19454		
Baltimore,	Pages 1 ment of Hitant: If iten jury or oth		20a. Method of Disposition  158urial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State HOL	emetery, crei Y SEPU	osition (Name of matory or other place ILCHRE CEI	METERY 1		WYN.	DMOORE,		YLVANI
Ball	permit. Departr Imports eny inji		21. Signature of Funeral Service License	Durbun		ERS-DURBO	S STREET	WESTMI	NSTE	.A. R, MD	21157 Approxim	
	Physician /Medical Examiner	j.	3a. Part   Enter the disease, or complication, or hear failure. List only on disease or condition resulting in death)  Sequentially list conditions.		2 Fd	A. + heye	sclere	\$ 15	arrest,		Interval B Onset and	etween
68760,	eath certificate be executed attending physicien and for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Undersing Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ								
P.O. Box (	Attending Physicien: The law requires that the death certifical rideath.  • closeth.  • ctor: After this certificate has been signed by the attending phy the funetal director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 200 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	□Ectopic pregnancy □ Other (specify) _	/			23d. Date of del Month	ivery Day	Year
rds, P	quires that n signed b uld be deta		Part II. Other significant conditions con	atributing to death but not resu	ulting in the u	inderlying cause giv	ren in Part I.			ise contribute to	the cause of obably 4	
Division of Vital Records,	: The law requir cate has been si , page 2 should I	Completed					, the	24a. Was auto perf 1 Yes		24b. Were au prior to death?	completion of	s available cause of
f Vita	hysician his certifi I director	To Be	25. Was case referred to medical examiner?	lospital: 1  Inpatient 2	ER/Outpatier	nt 3□ DOA Oth	or a	eath (Check only Home 5 Res		5 □Other (Spe	cify)	
sion o	eath. or: After ti	Certification:	27. Manner of Death  1 Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	M 1 🗆		28d. Describe				
Š O	i Diffe		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	<i>'</i> )			City or To	iwn, State			imber,
	To the Hospitel within 24 hours a To the Funeral Completely filled	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.								)(s)
)	To the To the Comp	W	29b. Signature and title of gertifier	nunul		29c. Licens	32 7 2		29d. Dai	e signed (Mont.	h, Dey, Year)	
5)	ALWIN.		30. Name and address of person who co	toner, MY	Sui	te 403	7505 (	Os ler Mx	T	owson	Mdz	1204
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Gow						

			1 - For Unpend Item #2.	State of M Ba,27,28a-f p	laryland er me G	1 / Dep 828 2/	artmen 1004 Tillicati	t of H	lealth a	and M	lental Hy	giene Reg. No.	2004	03091
	<b>.</b>		Decedent's Name (First, Middle, I	_ast)			-				2. Date of Dea		V	3. Time of Death
	Physic /Medi		ROBERT F. GOSHO	RN							January	Day 14.	2004	12:50 P <sup>M</sup>
	Exami		4a. Facility Name (If not institution, g	ive street and number	)		4b. City,	Town, or	Location	of Death	2	_	County of Death	12.50 1
			21130 Aquasco Ro	oad				A	quasc	o.		P	rince Ge	eorge's
	Funeral				ge (In yrs. Ia:	•	If Under Months		If Under Hours		8. Date of Birt (Month, Day			place (State or Foreign
	Director		218-54-5053	1 <del>X</del> M 2□F	<b>7</b> 5	Yrs.					Sept 1	4 19		/land
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City	Town or L	ocation							Od. Inside City Limits
	Aaryl sho	5		George's										1 □ Yes 2 □ No
	the tage	Directo	10e. Street and Number	ocorge 5	Aqua	1500	10f. Zip	Code				10a Citis	en of What Cour	
	with Se or	Ö		3								rog. Oniz		шуг
	ris 2:	Funerai	21130 Aquasco R	12. Was Decedent	Ever in U.S.	. 13.	Was Deced	0608 lent of Hi	spanic Ori	ain? (Sp	city Yes or No-	1 1	USA 4. Race - Americ	can Indian.
(0	r Items	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces'	?		if Yes, spec	rry Cuba	n, Mexican	, Puerto	Rican, etc.)		Black, White,	etc.
8	al', o	by	3 ☐ Widowed 4X Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	2 <b>∆</b> No	Specify:				Specify: Whi	te
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show sidical Exeminational by	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usua kind of wor	I Occupa	ation	t of work		16b. Kin	d of Business/Inc	dustry
7	S 3	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	lite.	DO NOT us	e retired,	)	i or work	''y			
2		S	7		F	'armer	<u> </u>					Farm		
p	d fa b	Be	17. Father's Name (First, Middle, La.	st)					18. Mothe	r's Name	(First, Middle,	Maiden S	Sumame)	
<u>≯</u>		ပို	Robert C. Gosho	=							Cummings			
Maryland	~ ~ ~ ~		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	l Route Numbe	r, City or	Town, State, Zip	Code)
	s f and street Health item 27 other tra		Beth B. Chappele	ar	Joon Die	PO Ec	x 27	Aqua	sco.		vland 2			
altimore,	to to		20a. Method of Disposition 1 □ Burial 2X Cremation 3	☐Removal from State	cen	netery, crei	natory or ot	her place			late .		ation - City or To	
<u>Ē</u> .			'4 □Donation 5 □ Other (Spec	city)	Metr		tan C				3-04	Alexa	andria,	VA
Bai	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Lic	MO(	0173	22	2. Name and	d Addres	s of Facility	y Ebe	erwein H	une	ral Serv	rices
	20240		Willes H	New		44	133 Wh	ite	Pls.	La.	White H	ls.	MD 206	95
			23a. Pan / Ent+ the dis-ase, or ck, or heart failure. List on	mplications that cause ly one cause on each I	d the death. ine.	Do not ent	er the mode	of dying	, such as	cardiac c	r respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a Arterioscl	erotic	cardio	vascula	ar di	sease	comp1	icated by	hypo	thermia	Onset and Death
<b>\$</b> -	/Medical Examiner		resulting in dealing	Due to (or as										
		-	Sequentially list conditions,	b. Due to (or as	3 000000000	non of):								
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce ory.								
	xecu and	Examiner	that initiated events resulting in death) Last	cDue to (or as	a conseque	nce of);								
8760	death certificate be executed e attending physician and id for use as the burial-transit	icai E				ŕ								
687	ficate phys s the	dic	<u> </u>	d										
Вох	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnanc	·V						22	d. Date of deliver	
ă	atter I for u	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	_		Ectopic pre Other (spe					23		ny Day Year
o.		ıysi	1 Yes 2 No	9□ Unknown		0_	3 0 11 101 (3)00							
۳.	res that the signed by the be detache		Part II. Other significant conditions	contributing to death t	out not resulti	ng in the u	nderlying ca	use give	n in Part I.		23e. Did to	рассо из	e contribute to the	e cause of death?
ģ	requires leen sign hould be	d by									1 □ Y	s 2 🗆	No 3 ☐ Proba	ably 4 Unknown
Vital Records,	>	Completed									24a. Was a		24h Mosa sutan	ou findings supilable
Re	0 4 0	E G									autops	y		psy findings available appletion of cause of
ß	i <b>ician:</b> Th certificate rector, pag	o C	25. Was case referred to medical								1 X Yes		1 XYes	2 No
		00	examiner? 1 ☑ Yes 2 ☐ No	Hospital:		2/Outpotion	t 3 DO	04-			(Check only on			
	ig Phys ter this teral di	: To	27. Manner of Death	28a Date of Inju	IIV 28	Bb. Time of		Bc. Injury Work	4 🗆 Mul	sing Hon	se 5 ☐ Heside 8d. Describe ho	w injury	occurred	at scene
<u>o</u>	토 중 : 불	tioi	1 ☐ Natural 5 ☐ Pending 2 ☑ Accident investigate	Found on 1/14/04		Injury nknown	м	Work′ 1 ☐ Y	? es 2 <b>X</b> ∃N	10		1 .	1	
	r Attsnu er deatt rector: by the	iţi	3 ☐ Suicide 6 ☐ Could not determine	be 28e. Place of Inj	ury - At home		eet, factory,	office					l environm 21/1/30°/Aqua	
Ö	afte safte	Certification:	4   Homicide	building, et	c. (Specity)					-	uasco M	_	ziio Aqua	isco ka.
	Hospitel 4 hours a Funeral I tely filled		29a. Certifier 1 ☐ Certifying F	hysician: To the best	of my knowle	edge, death	occurred a	t the time	e, date and	I place a	nd due to the ca	usole) a	nd manner as sta	ated.
		Medical	(Check only 20 Medical Exa	aminer: On the basis o and manner sta	t examination	and/or inv	estigation, i	in my opi	inion, deatl	h occurre	d at the time, da	ate and p	lace, and due to	the cause(s)
	To the within: To the comple	ž	29b. Signature and title of certifier	0 4.0			29c.	License	number		2	9d. Date	signed (Month, D	Day, Year)
			1 l wil	to My					O.C.M	1.E.		11	15/04	
L.			30. Name and address of person who	completed cause of c	leath (Item 20	3а) (Туре,	Print)				<u>l</u>	4	1-1-7	
1			J. Laron Locke	M.D.		1	11 Pe	nn S	treet	t, Ba	altimore	, Ma	ryland :	21201
	Sta		31. Date filed (Month, Day, Year)		ar's Signatur	0	Cart 1						-	
	Registr	ar	IAN 2 2	2HD/II		M. I	Lacall 1	9						

		1 - For State Registrar	State of Maryla	•	artment of rtificate of		F	Reg. No. ZUU4	03092
Physici /Medi	cal	Decedent's Name (First, Middle, La Carol Darlene G     Aa. Facility Name (If not institution, given the control of the co	oodman		4b. City, Town,	or Location of De	2. Date of Dea Month January	Day Year	3. Time of Death  10:30 P <sup>M</sup>
Examir Funeral Director	ier	6010 Suzanne Road 5. Social Security Number 6.3	3	s. last birthday) Yrs.	Waldo	rf If Under 24 H	rs. 8. Date of Birtl	v, Year)   Cou	place (State or Foreign ntry) inia
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examiner could be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Charles  10e. Street and Number  6010 Suzanne Roa  11. Marital Status  1 Never Married  3 Widowed 4 Divorced  15. Decedent's E (Specify only highest girle)  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Las Delmar Bramble	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:    ducation	U.S. 13.	dorf  10f. Zip Code  Was Decedent of If Yes, specify Cu	20601  Hispanic Origin?  Johan, Mexican, Puro  Specify:  upation  e during most of wred)  18. Mother's N	(Specify Yes or No- erto Rican, etc.)	10g. Citizen of What Cou USA  14. Race - Ameri Black, White Specify: W  16b. Kind of Business/Ir	10d. Inside City Limits 1 □ Yes 2 No Intry?  can Indian, etc.  Ihite  Idustry
Definitions, Wally permit. Pages 1 and 2 shoul Deperment of Health and M Important: If item 27 Is mant any injury or other traumati once.		19a. Informant's Name/Relationship  John Goodman  20a. Method of Disposition  1	Husband  Removal from State (by)  Hu	6010 Place of Disponentery, cre ntt Cre	Suzanne of matory or other permatory or other permatory 2. Name and Add	e Road, W	Date 4 24-04 wuntt Fune	20c. Location - City or T Valdorf, Mar	own, State ryland
Physician ate be executed whisicien and hysicien and he burial-transit	lical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	equence of):	eter the mode of d	yng, such as card			Approximate Interval Between Onset and Death
The law requires that the death certifica The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2√ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	atal death 3	⊒Ectopic pregnar ⊒ Other <i>(specify)</i>	псу		23d. Date of deliving Month	rery Day Year
w requires that the tent of th	by	Part II. Other significant conditions	contributing to death but not re	esulting in the u	underlying cause (	given in Part I.	23e. Did to	obacco use contribute to f	the cause of death?
ician: The law received the law received the law received the law received the last be ector, page 2 should be last be	Completed	25. Was case referred to medical				GE Blood of F	24a. Was autop perfor 1 Yes	sy prior to comed? death?	opsy findings available ompletion of cause of
ng Phys dter this c	Certification: To Be	examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigate  3 Suicide 6 Could not determine	28a. Date of Injury (Month, Day Year)		of 28c. In W	Other: 4 Nursing  Other: 4 Nursing  Other:  Yes 2 No	Home ST Resid	lence 6 Other (Special National Street and Number or Rur	
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the the	Medical Ce	29a. Certifier (Check only one)  29 Madical Example 20 Madical Example	hysician: To the best of my k minar: On the basis of exami and manner stated.	nowledge, dearnation and/or in	nvestigation, in my	time, date and play opinion, death oc	ccurred at the time, of	cause(s) and manner as state and place, and due to 29d. Date signed (Month,	o the cause(s)
BB9 St.	ate	30, have and address of person who	o completed cause of death (It	EW N	Print)	GALD	orr.	md. 2	0603

			1 - For Stete Registrar	State of Maryl		artment rtificate				giene Reg. No.	2004	03093
	Physici	an	1. Decedent's Name (First, Middle, Las				•		2. Date of Dea	Day	Year	3. Time of Death
)	/Medio Examir		Johanna Mary Godda  4a. Facility Name (If not institution, give			4b. City, To	own, or Locati	ion of Death	January		2004 County of Death	9:00 A <sup>M</sup>
			Anne Arundel Medic			Annapo				Ann	e Aruno	
	Funeral Director		5. Social Security Number 6. Security Number 11 216-03-0362 Usual Residence of Decedent	9X 7. Age (In:	yrs. last birthday Yrs.	Months	Year If Un Days Hou	nder 24 Hrs. Irs Min.	8. Date of Birt (Month, Da Apr. 5	y, Year)	-	nplace (State or Foreign untry) vland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, ite Madical Examilier must be notified at once.	Director	10a. State 10b. County Maryland Anne Arun 10e. Street and Number		City, Town or L	ocation	code			10g. Citiz	en of What Cou	10d. Inside City Limits 1 ☑ Yes 2 ☐ No untry?
	th with 23a o	ai D	14 Glen Ave			2140	1		τ	Jnite	d State	es
980	urs after dea al', or Items Examiner m	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates:	in U.S. 13.	Was Decede If Yes, specif 1 ☐ Yes 2			ecify Yes or No- Rican, etc.)		4. Race - Amer Black, White Specify: Whi	, etc.
21215-0036	ithin 72 ho ne. nen "natur nen "natur	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	edent's Usual kind of work DO NOT use	done durina r	most of workii	ng	16b. Kin	d of Business/I	ndustry
	filed within Hygiene. other than ent, the Ma	Co	12 17. Father's Name (First, Middle, Last)		Homem	aker	18 M	other's Name	(First, Middle,		Home	· · · ·
au(	ld be ental ked o ic eve	To Be	Louis Macek						gielska		ourname)	
Maryland	2 should and Men is marke surmatic		19a. Informant's Name/Relationship (7)	• •			Street and Nu	mber or Rura	l Route Numbe	r, City or	Town, State, Zi	p Code)
Z ű	and 2 lealth m 27 in		Ernest R. Goddard					T	ans, LA			
100	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐	I tollioval from State	b. Place of Dispo cemetery, cre				ate		ation - City or T	
Baltimore,	permit. P Departme Importan any injurt		4 □ Donation 5 □ Other (Specify,     21. Signature of Fire all Server) Didentifications		. Mary'	2. Name and	Address of Fa	1/26/ acility John louces	n M. Ta	ylor	Funera	aryland 1 Home,Inc. ,MD 21401
	Physician /Medical Examiner	ıer	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury)	a. Myoca	sequence of):	1	of dying, such		r respiratory an	rest,		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a con	sequence of):							
.O. Box 6	The law requires that the death certific Ite has been signed by the attending p age 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	23c. If yes, outcome of pre 1□Live birth 2□F 4□Pregnant at time 9□Unknown	etal death 3[	⊒Ectopic preg □ Other (spec				23	3d. Date of deliv	ery Day Year
s, D	quires that in signed b uld be deta	by	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	inderlying cau	se given in Pa	art I.	10.	bacco us		the cause of death?
Vital Record		Completed								sy med? 2/2 No	prior to co death?	opsy findings available impletion of cause of
	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 C ER/Outpatier	nt 3□ DOA	Othor		(Check only or		□Other (Speci	60
Division of	Attending Phy or death. ector: After thi by the funeral of		27. Magner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o		Injury at Work?	2	8d. Describe h			y)
Divis	in Signal	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Sp	ecify)		-		City or Tow	n, State)		al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 12 Certifying Phy (Check only one) 2 Medicel Exem	rsicien: To the best of my iner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at vestigation, in	the time, date my opinion, o	and place, a death occurre	nd due to the c d at the time, d	ause(s) a ate and p	nd manner as s lace, and due t	stated. o the cause(s)
	To the hwithin 24 To the f	Med	29b. Signature and title of certifier	g and mainter stated.		29c. L	icense numbe	er	2	9d. Date	signed (Month,	Day, Year)
			> Kel Tleter	- MD		0	2480	e		01	-22-	2004
			30. Name and address of person who c	ompleted cause of death (	Item 23a) (Type,	Print)	£ 1	tonop	dis n	1cf	3140	
	Sta Registr	-	31. Date filed (Month, Day, Year)  JAN 2 3 2	32. Registrar's Si	gnature	houth .		U		,		

		-	For State Registrar	Stat	e of M	arylan		artmer rtificat			and Me	ental Hyg	jiene Jeg. No.	004	03094
			1. Decedent's Name (First, Middle	, Last)								<ol><li>Date of Dea Month</li></ol>	th Day	Year	3. Time of Death
	Physicia /Medic		S'ANTA-	MAK	214	_	(	316	-EI	VA		01	14	2004	19:32 M
	Examin		4a. Fecility Name (If not institution							Location o				unty of Death	
			WASHINGTON	ADVER	1775	T HO	SPITAL	7.				RKMB			MERY
	Funeral		5. Social Security Number 212-55-5774	6. Sex 1 ☐ M 20)		Age (In yrs. 88	last birthday)		r 1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birth Month Pay une 28	Year	9. Birth	plece (State or Foreign ntry) entina
	Director				4,	- 00	Yrs.				μ	une 20	, 191	Arge	encina
П	and W	}	Usuel Residence of Decedent  10a. State 10b. County			10c. Cit	y, Town or Lo	cation				-			10d. Inside City Limits
	sho sho	ŏ	Maryland Monto	omerv				T:	koma	Parl	,				1X☐Yes 2 ☐ No
	28a-1	Director	10e. Street and Number	Ome i y					Code	Tuit		· · · · · · · · · · · · · · · · · · ·	10g. Citizer	n of What Cou	ntry?
	with with	₫	400 Belford	Place						20902	)		Δ	rgentir	12
	ns 23	Funeral	11. Marital Status	12. Was		nt Ever in U	.S. 13.	Was Dece	dent of Hi			city Yes or No- lican, etc.)		Race - Ameri	can Indian,
"	r Her	필	1 ☐ Never Married 2 ☐ Marr	ied 1 🗆	ed Force: Yes 2X		1							Black, White	ite
93	urs a	þ	3 Widowed 4 ☐ Divorced	Yea	s, Give r or Dates	<b>s</b> :		LAYES	2 🗆 No	эреспу.	Arge	ntiniar	I Sp	pecify: WI	
2-0	J within 72 hours after death with the Maryland jiene r than "natural", or Items 23a or 28a-f show I're Medical Examinat must be notified at	Completed	15. Deceder (Specify only highe	t's Education	eted)		16a. Dece	kind of wo	ork done d	turing most	t of workin	ıg	16b. Kind	of Business/Ir	ndustry
2	within ene. then	ign i	Elementary/Secondary (0-12)		ege (1-4o	r 5+)		DO NOT L	- 10				_		
2	Hygier Hygier Ather th	Š	0	(				Homer	naker		rde Name	(First, Middle,		Private	<u> </u>
pu		Be	17. Father's Name (First, Middle,	Last)						TO. MIUTIE	ii s ivailie			mamej	
χ	ould be I Mental narked c	မ	Juan Gigena	his Ottoma Onio	.4)		10h Maili		- /Street	and Number	e or Rumi	Unknov Route Numbe		our State 7	o Code)
Maryland 21215-0036	d 2 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Relations Osmar Leguiza		on)										<i>p</i> Code)
di.	and Heal		20a. Method of Disposition	mon (s	on)	20b. I						ma Park	_	tion - City or T	own, State
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		1 ☐ Burial 2 【XCremation		from Stat		Place of Dispo cemetery, crei				1177	2004			
Ε̈́	t. Partmer		* 4 □ Donation 5 □ Other (S			Un						2004 L			יices, P.A.
Bal	Dermi Depa mpo any ir		21. Signature of Juneral Service	LICETTO								e, Land			
_			23a. Part1. Enter the disease, o	complications	that caus	ad the dea								, 110 20	Approximate
			shock, or heart failure. List Immediate Cause (Final	only one caus	e on each	line.									Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	_ a	MY	DCA	CDIA quence of):		INF	AR	C7	1670		-	
	Examiner				200	16-6	-S 77 (	15	HE	DAD	TE	AIL	IRI		
		ē	Sequentially list conditions, if any, leading to immediate	b. — D	ue to (or	ds a consec	цивнов of).		// _	///-		,,,,			
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	C											
oʻ	te be executed ysician and se burial-transit		resulting in death) Last		ue to (or a	as a consec	quence of):								
1760,	- × 6	ical		d										-	
89	leath certificat attending phy I for use as th	Med	IF FEMALE:												
Вох	death certifica e attending ph id for use as th	Physician/Med	23b. Was decedent pregnant	10	Live birth	ne of pregn 2 □ Fet	al death 3	Ectopic p					230	<ol> <li>Date of delivered.</li> <li>Month</li> </ol>	very Day Year
	0 0 2	sici	in the past 12 months? 1 Yes 2 No		Pregnant Unknown	at ti <i>m</i> e of o	death 5[	Other (s	pecify)						,
P.0	that the de ed by the detached	Phy	9 Unknown  Part II. Other significant conditi		- 1	- but ast so	outting in the c	and a chainn		on in Part I		23e Did to	nhacco use	contribute to	the cause of death?
	eg ng	þ	Part II. Other significant conditi	ons contributin	g to death	n but not re	sulling in the L	inderlying	cause givi	en in raiti			/es 2□1		- M
Records,	v requir been si should	Completed													
ec	e law has b je 2 st	nple										24a. Was autop perfo	sy		opsy findings available empletion of cause of
=		ပ်											28 No	1 ☐ Yes	B⊄ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital					Oth.			Check onl o			
of	ys di≅	2	1 Yes 2 No		1 🗀 Inpa		ER/Outpatie		to be seen to be seen	4 🗀 🗚		ne 5 Resid			ify)
Ē		on	27. Menner of Death 1 Natural 5 ☐ Pendi	19	(Month,	njury Day Year)	Injury	" м	28c. Injun Worl	k? Yes 2□		ou. Describe i	iow inquity c	ocumba	
isio	Attending if death. ector: After by the fune	icat	3 ☐ Suicide 6 ☐ Could		Place of	Injury - At h	nome, farm, st					28f. Location (S	Street and I	Number or Ru	ral Route Number,
Division	after Direction by	Certification;	4 Homicide deter	ninea	building,	etc. (Spec	ify)		.,,			City or Tox	vn, State)		
_	spital ours neral filled	C	29a. Certifier Certifyi	ng Physicien:	To the be	est of my kn	owledge, dea	th occurre	d at the tin	ne, date ar	nd place, a	and due to the	cause(s) ar	nd manner as	stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medice		the basis d manner		ation and/or ir	vestigatio	n, in my o	pinion, dea	ath occurre	ed at the time,	date and pl	ace, and due	to the cause(s)
	ompl	Me	29b. Signature and title of contifi	or //					c. Licens					signed (Month	
			Acho	VI	en		KIN	1	10	603	319		1	114/	2004
^			30. Name and address of person	who complete	d cause o	of death (Ite	m 23a) (Type	, Print)	,	1		,			,
R			Hammer	Das	cie	76	00 C	arra	oll	Aven	ue,	lakom	a fari	C MI	)
1		ate	31. Date filed (Month, Day, Year 1 6 2	104	32. Reg	istrar's Sign	nature	N.				Takom			
	Regist	rar	DWW TO 7	A TOO	Colle	1	600				-4				

			For State Registrar	State	of Maryla		artment of rtificate o			lental Hy	gier Reg. N		004	0309
	Dharaisi		1. Decedent's Name (First, Middle	, Last)						2. Date of De		ay	Year	3. Time of Death
	Physici /Medic		ELIZABETH	W.		GRIFF	IN			JANUAR	Y	9, 2	004	11:09 PM
	Examin	er	4a. Facility Name (If not institution				4b. City, Town	, or Location	of Death		4	tc. County	of Death	
			SOUTHERN MARYI  5. Social Security Number	AND HOSP		NTER.	If Under 1 Yea	CLINTO ar If Under		9 Date of Bi				ORGE S
	Funeral Director		578-26-5274	1 M 24 F	7. Age (iii yis		Months Day		Min.	8. Date of Bi (Month, D. July	ay, Yea	1020	Coun	ish., DC
			Usual Residence of Decedent		0.5					July	10 1	1920	Wa	.sn., DC
	yland	. [	10a. State 10b. County		10c. C	ity, Town or Lo	cation						1	0d. Inside City Limits
	a-f el	ctor	Md. Prince	George'	s		Ft. Was	hingto	n					1 TYes 2 □ No
	ith th	Director	10e. Street and Number				10f. Zip Code	•			10g. (	Citizen of V	Vhat Coun	try?
	death with the Maryland ms 23a or 28a-f ehow funtative notified at		13310 Buchana					20744						tates
	er de	Funeral	11. Marital Status	Armed F			Was Decedent of f Yes, specify C	f Hispanic Ori uban, <mark>Mexica</mark> i	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	0-		e - Americ k, White,	
5	thin 72 hours after death with the Marylan e. en "natural", or Items 23e or 28e-1 ehow Medical Examinet must be notified at	by F	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	if Yes, G Year or	2 🔯 No live Dates:		1□Yes 2⊠N	lo Specify:				Specify	· Bla	ck
2-003p	2 hou	ed	15. Deceden	's Education		16a. Dece	dent's Usual Occ	cupation			16b.	Kind of Bu		
<u>.</u>	within 72 ene. then "na!	pie	(Specify only highes Elementary/Secondary (0-12)	1	(1-4or 5+)	(Give	kind of work do DO NOT use ret	ne during mos ired)	it of worki	ng				
7	¥ 6 € 5	Completed	10th	00.00	(, , , , , , , , , , , , , , , , , , ,		House	wife				Do	mest	ic
<u> </u>	be filed tal Hygid d other event, I	Be (	17. Father's Name (First, Middle,	Last)				18. Moth	er's Name	(First, Middle	, Maide	en Sumam	Θ)	
yland	ss 1 and 2 should be of Health and Mental litem 27 le marked or other traumatic eve	2	James Morgan							da Lewi				
Mar	2 she and le m		19a. Informant's Name/Relations				ng Address (Stre							
	1 and Health em 27 other tr		Barbara G. Mar 20a. Method of Disposition	shall /			.0 Bucha sition (Name of	nan Dr		t. Wash		ton.		
saitimore,	Pages nent of H		IX Burial 2 ☐ Cremation		n State	cemetery, crei	natory or other p							
	t. Pa ntmen ntant: njury		* 4 □ Donation 5 □ Other (S		M	7	et Ceme	,		5-04		Washi	Ingto	n, D.C.
a	permit. Pages Department of I Important: If Its any injury or o		Man Service	Ohyon	- Jal	00	425 Mar		Ca	apitol NE W				c. 0002
	1		23a. Part1. Enter the disease, or shock, or heart failure.	complications that	caused the dea	ath. Denot ent	er the mode of d	lying, such as	cardiac o	or respiratory a	rrest,		1.0	Approximate Interval Between
y.	Physician		Immediate Cause (Final disease or condition		(	itris	JA,	boit	fall	2			= 1	Onset and Death
	/Medical		resulting in death)	Due to	o (or as a conse	quence of):		201					- 12	my mess
	Examiner		Sequentially list conditions,	b										
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a conse	quence of):								
	cate be executed physician and the burial-transit	Kam	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	o (or as a conse	guence of):								
Š	be ex ician burial				7 (01 43 4 001130	444100 01).								
98/60	8 E =	dical		d										
×	at the death certific by the attending parached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregr	nancy						23d Dat	e of delive	n/
X Q Q	atter d for u	clar	in the past 12 months?		birth 2 ☐ Fer nant at time of		Ectopic pregnal Other (specify)					Mor		Day Year
j.	the c	nysi	9 Unknown	9□ Unk	помп									
<u>s</u>	The law requires that the te has been signed by the has been signed by the hage 2 should be detache	by PI	Part II. Other significant condition	ons contributing to	death but not re		. \	given in Part I		23e. Did	tobacco	use contr	ibute to th	e cause of death?
Ĕ	quire en sig uld b		- gastros.	Vlestin	1/13	wal	-			1 🗆	Yes	2 🗆 No	3 🗌 Proba	ably 4 Onknown
Vital Record	aw re s bee	Completed	0							24a. Was		24b. V	Vere autor	osy findings available inpletion of cause of
Ĭ	The I	mo									ormed?		eath?	
Ē	sician: The law certificate has t irector, page 2 s	Be C	25. Was case referred to medical examiner?					26. Place	of Death	(Check only				
01 <	> 0 D	To	1 Yes 2 No	Hospital:	patient 2	☐ ER/Outpatier	t 3 DOA	Other: 4 Nu	rsing Hor	me 5 Res	idence	6 □Othe	er (Specify	)
	ding Phi h. Atter thi funeral		27. Manner Death 1 ☐ Itural 5 ☐ Pendin	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury	V	Vork?		28d. Describe	how in	jury occurr	ed	
S 10	Attendideath.	cati	2 Accident investig	gation				☐ Yes 2☐	-					
DIVISION	l or Atten after deati Director:	Certification:	4 Homicide determ	ined 200. Flat	ce of Injury - At I ding, etc. <i>(Sp</i> ec	home, farm, str sify)	eet, factory, offic	28	1	28f. Location ( City or To			er or Rurai	Route Number,
	lospital hours a uneral C		29a. Certifier 1 Certifyin	g Physicien: To th	a bact of my ke	Soulodge death	a consumed at the	time date as	d olace i	and due to the		(a) and ma		
	T 4 IT 5	edical	(Check only 2 Medical one)	Examiner: On the	basis of examir nner stated.	nation and/or in	vestigation, in m	y opinion, dea	th occurr	ed at the time,	date a	nd place, a	ind due to	the cause(s)
1	within 2 To the	Me	29b. Signature and the prentifie	1			29c. Lice	nse number			29d. D	ate signed	(Month, L	Day, Year)
Ċ	3) ·		1				50	45-4			Ja	nu	79	10,04
y	61		30. Name and address of person		-		Print)							
	- J			i à Ave	Sul	- 3 - 0	11311	ves s	651,	JMD	2	090	2	
	Sta Registi		JAN 1 6 2004		Registrar's Sign	iature								

ORIGINAL

			For AMENDED#17, State of Maryland / Department of Health and 1-State Pagistrar DAN,1-30-04,st.marysco. Certificate of Death		iene 2 0 0 4	03096
	4.		Decedent's Name (First, Middle, Last)	2. Date of Deat	th	3. Time of Death
	Physicia			January	Day Yeer 7 21. 2004	5:10 a.m.
	/Medic		Arthur Alfred Helgerson  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat		4c. County of Deelf	
	Examin	er				
			23575 Town Creek Drive Lexington  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	9 Date of Birth	St. Mar	y S place (State or Foreign
	Funeral		Months Days Hours Min.		Year) Cou	e Island
	Director	.	037 01 8054 84 Yrs.	riay 17,	TOTO KITOU	.e island
	land W		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary i sh	ō	Maryland St. Mary's Lexington Park			1 ☐ Yes 2 個 No
	28a-	Director	10e. Street and Number 10f. Zip Code	1	log. Citizen of What Cor	intry?
	with a or	₫	23575 Town Creek Drive 20653		United Sta	+00
	es 23	era		Specify Yes or No-		
	d within 72 hours after death with the Maryland piene. If then "neturel", or Items 23s or 28s-f show the Medical Exant et must be rouffed at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 2 No 1945-  13. Was Decedent of Hispanic Origin? (S	to Rican, etc.)	Black, White	, etc.
36	rs aff	by	3 ☐ Widowed 4 ☐ Divorced   1978   1 ☐ Yes 2 No Specify:		Specify: Wh	ite
응	hou hou	pa	15 Decedent's Education 16a Decedent's Usual Occupation		16b. Kind of Business/l	ndustry
21215-0036	n 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	rking		
12	within ene. than	mc	Elementary/Secondary (0-12) College (1-4or 5+) 8 Medical Officer		U.S. Nav	· v
22	Hygie Hygie other		The state of the s	me (First, Middle, i		J
ano	ed ta b	Be	ARTHUR	a Carlson	n	
Ë	2 should b and Ment Is marked aumatic e	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Re			in Code)
Maryland	~ ~ ~ ~				,	
	1 and 1 Health em 27	Ų.	Elna F. Helgerson / Wife 23575 Town Creek Drive  20a. Method of Disposition (Name of		20c. Location - City or	
0		14	1 ☐ Burial 2 ☐ Cremation 3 ■ Removal from State cemetery, crematory or other place)		•	
Baltimore,	permit. Page Department o Important: If sny injury or once.					Massachusett
39	Depariment Department Importment		21. Signature of European Superal Supe			
_	0 D ≥ ∞ α		Edward N. Brinsfield, Jr. M00052 22955 Hollywood Ro			
			23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician	9	Immediate Cause (Final disease or condition	Tuelm	36110031	Oriset and Boarn
	/Medical		resulting in death)  Due to (or as a consequence of):	1 - 0	1	700
	Examiner		Sequentially list conditions, b.	005	CD,	2 1/5
100	n =	ner	if any, leading to immediate Due to (or as a consequence of):			1.7
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	1) (	scase	15485
ó	an a		resulting in death) Last Due to (or as a consequence of):			501
8760,	cate be executed ohysician and the burial-transit	Physician/Medical	1 THERTENSION			1091
9	tifica ng ph as th	Med	To the part of the			1
Вох	eath certific attending p	Ş	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	
	deat e att	icla	in the past 12 months?  1   Ves 2   No.   4   Pregnant at time of death 5   Other (specify)		Month	Day Year
0	that the ded by the detached	hys	9 Unknown			
<u>d</u>	res tha signed be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
of Vital Records,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as		Diabotes Melhing	1 🗆 Yı	es 2□No 3□Pro	bably 4 Unknown
00	w requir been si should	Completed		24a. Was a	n 24b. Were au	opsy findings available
Re	The lav	m	HUPON CLANT TO PLANT	autops	mied?   death?	ompletion of cause of
a		e C	25. Was case referred to medical 26. Place of De	1  Yes :	1	2 140
⋝		o B	examiner? Userstal: Other	10	ence 6 Other (Spec	(fel
of			27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ow injury occurred	ny)
on	Attending Indeath.	tion	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
S	ttendii death. ctor: A y the fu	lica	5 Could get be		treet and Number or Ru	ral Route Number,
Division	or Attendate death Director:	Certification:	3   Suicide   Su	City or Town	n, State)	
	Hospital or 24 hours afte Funeral Dire tely filled in b	- 1	29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the c	ause(s) and manner as	stated.
	e Hospital 24 hours e Funeral letely filled	edical	(Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence)			
	To the Hospital or At within 24 hours after C To the Funeral Direct completely filled in by	Me	29b. Signature and little of certifier 29c. License number	2	9d. Date signed (Month	, Day, Year)
	F \$ F ŏ		i Mil		Ianuary 22	200/
•	11 10		D23634		January 22,	2004
	ON		30. Name and address of person who combleted en (se of death (Item 23a) (Type, Print)	1 mood N	Maruland 20	636
		2 .	Adinath A. Patil, M.D., 24035 Three Notch Road, Hol	Tywood, I	alyland 20	0.50
4	Sta Registi		JAN 2 3 2004			
			JAN 6			

# Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

				State of Ivid	ai yiai	Cert	ificate o	f Death		eg. No.	U 4	0309
			1. Decedent's Name (First, Middle, Lest	)					2. Date of Dee Month	th Day V	ear	3. Time of Death
	Physici /Medic		Mary-Alice Hau	ıpt					Jan. 1	7, 2004	+	11:40 AM
	Examin	er	4e Fecility Name (If not institution, give					4b. City, Town, or		4c. County of	Death	
			Charles County D					LaP1at		Charl		
	Funeral Director		5. Social Security Number 6. Se 557–14–7258  Usuel Residence of Decedent	х 7. Ag	e (In yrs. 85	est birthday) Yrs.	If Under 1 Yes Months Day			, Year)	Birthple Counti	ece (State or Foreign ry) rado
	pue ≱ =		10a. State 10b. County		10c. Cit	y, Town or Loca	ation		.,		10	d. Inside City Limits
	Many	ក្	MD Char	les	H11	ghesvi	11e					1 ☐ Yes 2 🛛 No
	1 the	<u>9</u>	10e. Street end Number			0	10f. Zip Code	)	1	0g. Citizen of Wha	at Count	ry?
	h wit	<u>a</u>	15470 Homeland	Dr.			20	0637		USA	1	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If them 27 is marked other than "natural", or theme 23a or 28a-f show saft injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give			as Decedent o Yes, specify Co	f Hispanic Origin? (Suban, Mexican, Puer lo <i>Specity:</i>	Specify Yes or No- to Rican, etc.)	14. Race - Black, Specify:	America White, e	
21215-0020	fural Ex	象	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:		16a Decede	nt's Usual Occ	unation		16b. Kind of Busin	Whit	
7	in 72	Completed	(Specify only highest gred	e completed)		(Give ki	ind of work dor O NOT use reti	ne during most of wo ired)	rking	TOD. TAING OF BUSIN	1033/11/00	25li y
77	the the	E O	Elementary/Secondary (0-12)	College (1-4or 5	i+)		1 Teac			Educati	on	
0	Hyg other,	BeC	17. Father's Neme (First, Middle, Lest)			Denoc	JI ICac		me (First, Middle, I		.011	
Maryland	Aente de la la la la la la la la la la la la la	ToB	John McCunniff					Katha	rine Grah	nam		
ary	short s		19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailing	Address (Stre	et and Number or R	ural Route Number	, City or Town, Sta	ate, Zip (	Code)
Σ	alth 27 i		Katharine L. Laugh	ton/Daugh		15470	Homela:	nd Drive	Hu hesvil	le, Mary	land	1 20637
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	Ramoval from State	20b. F	Place of Disposi cemetery, crema	tion (Name of atory or other p	lace)	January	20c. Location - Cit	ty or Tow	vn, State
Ĕ	Pages ment of ant: If its ury or o		4 Donation 5 Other (Specify)		Br	insfiel	d-Echo	1s Crem.	19,2004	Charlott	e Ha	a11, MD
Baltimore,	permit. Depart Import any Inj		21. Signature of Funeral Service Licens	styles	M00			fress of Facility Br: ree Notch				Hme.,P.A.
			23a. Pert1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused			the mode of d	ying, such as cardia	c or respiratory arr	est,		Approximate Interval Between
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. prec	mo	galan			1			Onset and Death
		Jer		•	DUB 10 (C	or as a consequ	ence on.				1	
	tificata be executed ng physician end as the burial-transit	edicai Examiner	Sequentially list conditions,	b	Due to (c	or as a consequ	ence of):				-	
o	e exe	Ĕ	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury	_								
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		_	L,	d							j	
Bo	attend for us	jan									1	
P.O. Box	ha de / the a	Physician/N	Part II. Other significant conditions con	ntributing to death bu	ut not res	ulting in the und	derlying cause	given in Part I.				the cause of death?
	thet the	4	idypertens	ion					1 □ ¥	es 2□No 3 <u>J</u>	Probl	ably 4 □ Unknown
Vital Records,	w requiras thet tha death cer bean signed by the attendir should be datached for usa	Completed by	dysphage						24a. Was a perform		avai com	re autopsy findings ilable prior to apletion of cause eath?
æ	The law i	E							1 Y	2210	10	Yes 2□ No
ta	iclan: The certificeta rector, pag	Bec	25. Was case referred to medical					26. Place of De	ath (Check only on	ne)		
<b>&gt;</b>	5 00	To E	examiner?	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatient	3□ DOA	Other: 4 Nursing H	lome 5□ Reside	ence 6 Other	(Specity)	)
ion of	Attending Physic death.  ctor: After this by the funeral d		27. Manner of Death  1 Naturel 5 Pending 2 Accident investigation	28e. Dete of Inju (Month, De	ry y Year)	28b. Time of Injury	28c. In W M 1	juryat łork? ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred		
-	7 4 5 5	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injubulating, etc.	ury - At h	ome, farm, stree (y)	et, factory, offic	ee	28f. Location (St City or Town	treet and Number ( n, State)	or Rural	Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled it	edical	(Check only 2 Medical Exami		examina							
	the I	Med	one) 29b. Signature and title of certifier	and manner sta	ited.		29c Lice	nse number	2	9d. Date signed (#	Month D	Pav. Yeer)
	5 <u>₹ 5 </u> <u>9</u>	_	A D A C	- (1)								
	200		I IT WE	malator and a	and the	n 02a) /T D		3892		January :	19,	2004
(	74		30. Name end address of person who co	MENT C				NE CTA 51	E (or) CUX	HOORE, M	d) "	20602
	Sta Registr	100	31. Date filed (Month, Day, Year)	32. Registra			madle A	*				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🥌 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 8:16 AM **Physician** Mary Helen Hayden January 14, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 36986 Bushwood Wharf Rd. Bushwood St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F 217-36-6674 68 Yrs Director August 16,1935 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show 1 ☐ Yes 2X No Directo Maryland St. Mary's Bushwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36986 Bushwood Wharf Rd. 20618 USA death Funera 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. and It item 27 is marked other than "natural", or lite any or other than that I have teumatic avent, the Mental Examine any or other treumatic avent, the Mental Examine any 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2🛣 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: Specify: þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lester Joseph Russell Mary Joseph Gibson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Hayden Niece 22087 Oscar Hayden Rd. Bushwood, MD 20618 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Sacked Heart Cemetery 17, 2004 Bushwood, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service, 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20 sehret Part 1. Enter the diseased or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CADNIANCER **Physician** METASTATIC 18 months resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy ŏ Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. been signed ģ 90 2- No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? certificate 1 Yes 2010 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural М 1 Yes 2 No 2 Accident Director: filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1/15/04 imo D 50696 GILLOOK SNO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEGNMEDTONN, MD 20650 CHHABKA, GURDELP S. POBUX 527 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 15 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend item#19b State of Maryland / Department of Health and Mental Hygiene RegistrerPer FH 1/22/04 HCHD LM Certificate of Death Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yee **Physician** 10:27 AM anvary 9 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Age (In yrs. last birthday) -Kurtord NFOYOL Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□F Yrs. Manjana Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow Injury or other treumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 420 Che 21001 Funeral Was Decedent Ever in U.S. Amped Forces? 1 K Yes 2 □ No If Yes, Give Year or Dates: Vi Chrcun 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced "neturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene importent; if item 27 is marked other then "ne any Injury or other treumatic aven" Elementary/Secondary (0-12) College (1-4or 5+) SCOVICE US GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, C Barbara Ussard Sister 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Fineral Home; W.D Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) NEWMONIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 Unknown Pagul. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 Probably 4 🗍 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 1 Tes 2 🗆 No 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 No Medical Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4641 64 who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Month, Day, Year)

32. Registrar's Signature

21

			1 - State Registrar	ate of Maryland		rtment of H		and Ment	tal Hygie		03100
			1. Decedent's Name (First, Middle, Last)						ate of Death		3. Time of Death
	Physici /Medio		Archie B. Hill, Jr.						MONTH NUDRU	Dey 2004	2130 M
	Examin		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	/			4c. County of Dee	
			PENINSULA REGIONA	Medical Co.	411		015641	/		NICON	1100
	Funeral Director		5. Social Security Number 6. Sex XX M 2	7. Age (In yrs. last	Yrs.	Months Days	If Under	24 Hrs. 8. D Min. 11	ate of Birth Month, Day, Ye 4-192	9. Bi	nthplace (State or Foreign ountry) Md.
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loc	ation					10d. Inside City Limits
	Manyli f sho	ō	Md. Wicomico	Salis							1 Tes Z No
	288-	Director	10e. Street and Number			10f. Zip Code			10g	Citizen of What C	ountry?
	3a or		6128 Florence St.			21804				USA	· · · · · · · · · · · · · · · · · · ·
	death	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S.	13, W	as Decedent of Hi Yes, specify Cuba	ispanic Ori	gin? (Specify )	res or No-	14. Race - Am	
336	2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other than "naturel", or Itams 23a or 28a-1 show aumatic event, the Madical Examinar investible notified at	by	1 Never Married 2 Married 1	med Forces? ŠYes 2⊡No ∕es, Give WWII ar or Dates: WWII		Tes, specify Cuba ☐ Yes 2 No	Specify:	, Риепо нісап	, etc.)	Black, Whi	<sub>te,etc.</sub> White
Ö	72 ho	Completed	15. Decedent's Education	10	6a. Decede	nt's Usual Occupa	ation		16b	. Kind of Business	/Industry
215	thin 7	nple	(Specify only highest grade com Elementary/Secondary (0-12)	ellege (1-4or 5+)	life. De	ind of work done of O NOT use retired	during most ()	t of working			
2	filed will Hygien other th	Con	12	1	Manag	er				ire Comp	any
lnd	tal H d oth	Be	17. Father's Name (First, Middle, Last)						t, Middle, Maid		
<u> </u>	d Men d Men narke	ို	Archie B. Hill, Sr.	:-n	al 44 W			sie Hil			
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic expose.		19a. Informant's Name/Relationship (Туре, Pr Keith Hill, Son			acific A				ty or Town, State, 21804	Zip Code)
Je,	ss 1 a of Hea item		20a. Method of Disposition		of Disposi	ition (Name of atory or other place	(e)	Date	20c	. Location - City or	Town, State
Ē	Page nent cont: If		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ Remov `4 ☐ Donation 5 ☐ Other (Specify)			of Delm		01-21-0	4 D	elmar, D	e.
Baltimore,	amit. apartr aport ny inji		21. Signature of Funeral Service Licensee		22.	Name and Addres	s of Facility	У			
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			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. D se on each line.	o not enter	the mode of dying	g, such as	cardiac or resp	oratory arrest,	,,,,	Approximate Interval Between
	Physician		disease or condition	PNEUN	70~	1 A					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	ce of):						
		-	Sequentially list conditions, b	Due to (or as a consequenc	na nili						
	nsit	nlne	cause. Enter Underlying Cause (Disease or injury	out to to, as a consequent	ad Oi).						
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8760	icate be executed physician and the burial-transit	dlcall	d								
9	tificat ng ph) as th	led									
ŏ	leath certific attending p	an/N	230. Was decedent pregnant	es, outcome of pregnancy Live birth 2 ☐ Fetal dea	uth 3∏E	ectopic pregnancy				23d. Date of de	1
O. B	e dea the att	Physician/Me	1 Yes 2 No	Pregnant at time of death		Other (specify)				Month	Day Year
٦.	res that the de signed by the a be detached to	Phy	9 ☐ Unknown Part II. Other significant conditions contributions								
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	PENAL			errying cause give	en in Part I.				o the cause of death?
ဝင္ပ	as bed 2 sho	Completed						2	4a. Was an	24b. Were au	utopsy findings available
ř		Com						11	autopsy performed′ ☐ Yes 2 ☑	?」  death?	completion of cause of 2 □ No
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<u>s</u>	of the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	Diagonal Initiation of the second			/es 2□N				
Division of	i Dift o	Certification:	4 Homicide determined	. Place of Injury - At home, building, etc. (Specify)	farm, stree	ot, factory, office		28f. Lo	ity or Town, St	and Number or Ru ate)	ural Route Number,
	Hospitel or 24 hours afte Funeral Dir stely filled in I		29a. Certifier 1 Certifying Physician:	To the best of my knowled	ne death o	occurred at the tim	e date and	Inlace and du	e to the cause	(c) and manner as	ctated
	thin 24 hours at the Funeral mptetely filled	edical	(Check only 2 Medical Examiner: O	n the basis of examination and manner stated.	and/or inve	stigation, in my op	pinion, death	h occurred at t	he time, date a	and place, and due	to the cause(s)
	To the within 2.  To the formplete	Me	29b. Signature and title of certifier			29c. License	number		29d. [	Date signed (Monta	h. Dey, Year)
			Polet allen	-, M. D.		DA	9168		1	119/04	
4			30. Name and address of person who complete								
			FOBERT ALLEN		G 5	DIVII.	400	500 /3	4 = 1	BILY	10 41504
	Sta Registra		31. Date filed (Month, Day, Year)  JAN 2 0 2004	32. Registrar's Signature	4	Spark	1	,		,	
	, legisti		JAN & V 2004	7	~	popula	-				

AKG	1- State of Maryland / Do State of Maryland / Do Registrar	epartment of Health and 110/04 tas Certificate of Death	Mental Hygie Reg.  2. Date of Death	ne 2004	0310
Physician /Medical	1. Decedent's Name (First, Middle, Last)  DENARD  . HI	CKMAN	Month	Day Year 7, 2004	3. Time of Death
Examiner	4a. Fprity Name (Knot institution pive street and number) 6500 block of Indian Head Highway	4b. City, Town, or Location of Deat Ft. Washington	h	4c. County of Death Prince Geo	orge's
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birth 26 Yr	Months Days   Hours   Min	(Month, Day, Ye		place (State or Foreigntry)  ngton, DC.
Maryland Ifed at	10a. State 10b. County 10c. City, Town	or Location Jashington			10d. Inside City Limits 1 XYes 2 No
h with the Mar 13a or 28a-1 el st by notified al Director	10e. Street and Number 8204 Alcoa Drive	10f. Zip Code 20744	10g.	Citizen of What Cou	ntry?
be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural; or items 23a or 28a-f show event, the Medical Examination is sent, the Medical Examination is sent.  Be Completed by Funeral Director	11. Marital Status  1 ☒ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Blac	etc.
e filed within 72 hou al Hygiene. other than "natura vent, I're Madical E Se Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Vo	ecedent's Usual Occupation Give kind of work done during most of wo ife. DO NOT use retired) L./Firefighter/ Lab	orer 16b	. Kind of Business/In	dustry
B is b w w	17. Father's Name (First, Middle, Last) Fentress A. Hickman	Shirle	-	Eva	
s 1 and 2 should if Health and Mer item 27 is marke other treumatic		Mailing Address (Street and Number or Ric 14 Alcoa Dr. Ft. Washing			
Pages 1 ment of He ant: If iten ury or oth	20a. Method of Disposition  1 Aburial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	Disposition (Name of crematory or other place)  11/1  15/07	6/04 Ga	Location - City or To rner, NC.	own, State
permit. Pages Department of Important: If it any injury or o	21. Signature of Foneral Service Licensee  WWW HOI 257	22. Name and Address of Facility Bianchi F.S. 814 Upshur	St. NW, Was	hington, DC.	20011
Physician /Medical Examiner	23a. Part1. Ertigif the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of the conditions).	<u>S</u>	c or respiratory arrest,		Approximate Interval Between Onset and Death
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	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year
igne be d	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death? pably 4 □Unknown
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Physician: The this certificate ral director, page TO Be Co	25. Was case referred to medical examiner?  157 Vos. 2 DNo. Hospital: 1 Dispersion to DEPOyee.	Other	th (Check only one)	. 50.	
nding Physith: The this efuneral diagrams.	1 ★ Yes 2 No	ne of 28c. Injury at Work?	ome 5 Residence 28d. Describe how in Special SM UN		
To the Hospitel or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funeral Medical Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fam building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St	and Number or Rura late)	0 4
To the Hospitel within 24 hours a To the Funers! I completely filled i	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, and manner stated.	death or urred at the time, date and place	, and due to the cause rred at the time, date	e(s) and manner as si and place, and due to	tated. the cause(s)
withir To th comp	29b. Signature and title of certifier	29c. License number	1	Date signed (Month,	
(2)	30. Name and address of person who completed cause of death (Item 23a) (Tr				
State	31. Date filed (Month, Day, Year)  2. Registrar's Signature	TTT TOM DURCE	, LALCHIOL	C, IMILYIM	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:50A.M. January Charles Lejune Harvey 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BURN ARUNDEL ITAL Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1₩ 2□ F Days 231-09-6522 89 1914 Virginia 23 Jun Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-1 show 7 Is marked other than "natural", or Items 23a or 28a-1 show traumatic event, the Medical Examinating Landillish at 1 Yes 2 No Directo MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21114 2914 Middlebridge Court U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 [XYes 2 □ No If Yes, Give Year or Dates: 44-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Black ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 3rd Private Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Hattie Hill Abraham Harvey ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 1342 Burlington Drive; Odenton, MD 21113 William Harvey other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Roosevelt Mem Pk i01/21/04 Chesapeake, VA `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert O. Freeman Funeral 21. Signature of Funeral Service Licenses H Street, N.E. Svc; 1353 Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** metustatic resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by pe 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has l irector, page 2 s 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient မှ 2 ER/Outpatient 3 DOA 1 🗌 Yes this Director: After that in by the funeral 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 5 ☐ Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours aft

To the Funeral DI

completely filled in 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Suml

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ess of person who completed cause of death (Item 23a) (Type, Print)

2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2004 Month **Physician** 10 TAMES EDWARD HAYNES 20:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 63 Yrs Director 227-50-6890 10 1941 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ast be notified at 1 X Yes 2 No Director PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with items 23a or 13310 New Acadia Lane # 306 20774 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) The Medical Exp. dreft Black, White, etc. tw□Yes 2□NoAir If Yes, Give Year or Dates: force 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 Black. 1 ☐ Yes 2 No δ Specify: Specify. 3 Widowed 4 Divorced naturai Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 2+ D.C. Special Police Government other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any light or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Sumame) Be George Haynes **Zlphia** Cuffee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haynes/Wife Beverly 13310 New Acadia Ln. # 306 Upper Marlboro, Md. 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Veterans National 1-20-2004 Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Respiratory Failure **Physician** /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Cerebral Vascular Accident or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Atrial Fibrillation Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4∑☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy ninea/ 2∰ No certificate rs after deau...
ral Director: After this ceru.....
ral by the tuneral director, pr 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: A Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely tilled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0050209 1-11-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Shen M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) State Registrar

			For	State of Maryland / Depa	artment of Health and M	_	
			1 - Stete Registrar		rtificate of Death		3. No. 4 UJ U4
	Physici /Medic		1. Decedent's Name (First, Middle, Last,  Rose Lee Insle			2. Date of Death Month January	Dey 11, 2004 1:55 P M
	Examin		4e. Fecility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Deeth
		4	St. Mary's Nursing	g Center	Leonardtown		St. Mary's
	Funeral Director		5. Social Security Number 6. Sec 577-22-4907	7. Age (In yrs. last birthday)  88 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 1 November 2	yeer) 9. Birthplace (State or Foreign Country) 1915 Maryland
	yland how		Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	the Mar	Funeral Director	Maryland St. Mary  10e. Street and Number	s Hollyw	vood 10f. Zip Code	10	1 ☐ Yes 2 ☒ No g. Citizen of What Country?
	3a or	0	45341 Nats Creek R	oad	20636		USA
	ms 2	Jere	11. Marital Status		Was Decedent of Hispanic Origin? (Spot If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - American Indian,
36	72 hours after death with the Maryland Insture!', or Itams 23a or 28e-f ehow Alcel Executes must be rediffed at	by Fur	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 TVes 2 VINo	1 ☐ Yes 2 No Specify:	Hican, etc.)	Black, White, etc.  Specify: White
ŏ	2 hou	ted	15. Decedent's Edu		dent's Usual Occupation kind of work done during most of work	ing 10	6b. Kind of Business/Industry
121	e filed within 7 al Hygiene. I other than "n vent, the Med	Completed by	(Specify only highest grad	College (1-4or 5+)	iologist	, ig	Hospital
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f ehow other traumatic event, it a Medical Exact instruction	Be	17. Father's Name (First, Middle, Last)  James Ki		18. Mother's Name	e (First, Middle, Ma	aiden Sumame)
Ž	should be ind Mental i marked umatic ev	은	19a. Informant's Name/Relationship (T)	rpe, Print) 19b. Mailir	ng Address (Street and Number or Rura	al Route Number,	City or Town, State, Zip Code)
Ž	and 2:		John Harrison Ins	ley/Husband 4534	1 Nats Creek Road	Hollywoo	d. MD 20636
re,	s 1 an of Heal item 2		20a. Method of Disposition	20b. Place of Dispo			Oc. Location - City or Town, State
Ē	Pages nent of ant: If it ary or o		1 XBurial 2 ☐ Cremation 3 ☐ F  *4 ☐ Donation 5 ☐ Other (Specify)	St. John	's Cemetery 1/15/	2004 Н	ollywood, Maryland
Balt	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		21. Signature of Funeral Service Licens	88 22 Suur	2. Name and Address of Facility Mattingley-Gar P.O. Box 270 Leo	diner Funer nardtown, M	cal Home, P.A.
	with the second		23a. Part1: Enter the disease, or compleshock, or heart failure. List only of	ications that caused the death. Do not ent			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (cr.) a consequence of:	long Failer	2	Onset and Death
2	Examiner			Vahalo	allThromb	oses	with
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Jarying Cause (Disease or injury	Due to (or as a consequence of):	0 1		
	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c			
760,	e be executed ysician and e burial-transit	alEx	1030king in dodiny case	Due to (or as a consequence of):			
687	cate t physic			d			
Box	death certificate e attending phys id for use as the	Physiclan/Medlo	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No	4 Pregnant at time of death 5 □	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.0	at the de by the a	hys	9 Unknown	9□ Unknown			
Ś	requires that een signed b hould be deta	by	Part II. Other significant conditions co	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Record	law as b	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
a		e Co	25. Was case referred to medical		OC Place of Docat	1 Yes 2	No 1 Yes 2 No
Vital	Physician: this certifica ral director, p	o Be	evaminer?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Other		ce 6 Other (Specify)
on of	ling After fune	<b>-</b>	27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Yeer)  28b. Time o Injury		28d. Describe how	
Division	or Atten tter deat irector: n by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	Hospita 4 hours uneral ely fille	ledical C	(Check only 2 Nedical Exam	sician: To the best of my knowledge, deatliner: On the basis of examination and/or in			
	To the I within 2. To the I complete	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	290	d. Date signed (Month, Day, Year)
)	0 1 % 1		· Jasa	borlos MI	D0648	7	1-13-04
			/ /	ompired cause of death (It in 23a) (Type,			
	Sta	to	Patrick J. Jarboe, MD 31. Date filed (Month Day, Year)	240B5 Three Notch Road H	ollywood, Maryland 206	36	
	Regist		JAN 15	2004 Magaza 25	Back		

DHMH 17 Rev 1/2001

ORIGINAL

			1- For State of Maryland / Dep	artment of Health and M rtificate of Death	lental Hygier	2004	03105
	Physici		1. Decedent's Name (First, Middle, Last)  JEANETTE INSLEY		2. Date of Death 1/10/04	Day Year	3. Time of Death 9:17P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  ATRIA	4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMIC	co
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye 6/19/21	ear) 9. Birthp Cour MD	place (State or Foreign ntry)
	Maryland a-f show	tor	Usual Residence of Decedent				10d. Inside City Limits  X☐ Yes 2☐ No
	h with the 23a or 28	Funeral Director	10e. Street and Number 1110 HEALTHWAY DR.	10f. Zip Code 21801	, -	Citizen of What Coul USA	ntry?
920	within 72 hours after death with the Maryland ene. than "natural", or itama 23a or 28a-1 show ha Madical Examinar must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Not widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Sive Year or Dates:	Was Decedent of Hispanic Origin? (Spr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WI	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", any injury or other traumatic event, it a Madical Example.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) TEACI	dent's Usual Occupation a kind of work done during most of worki DO NDT use retired) IER	wi Wi	o. Kind of Business/In COMICO CHOOLS	•
Maryland	should be filed withind Mental Hygiene. s marked other than umatic evant, Ite M	To Be C	17. Father's Name (First, Middle, Last)  ARTHUR M. RENCHER  19a. Informant's Name/Relationship (Type, Print)  19b. Mail		HIBBERD		2 Code)
	1 and 2 si Health an am 27 is i thar traur			SELWOOD RD.RICE	HMOND, VA		
Baltimore,	Pages tment of H tant: It its jury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BIVALVE	CEMETERY 1/16	/04 BI	VALVE, MI	
Bal	permit. Departr Imports any inj		C offenn Rovel in 1100410	ÍESSICK FÜNERAL BIVALVE, MD 218	14	BOX 61	
	Physician /Medical Examiner	J.	resulting in death)  Due to (or as a consequence of):	Can Dio Unsalla a			Approximate Interval Between Onset and Death
8760,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, isating to immudate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Cus to (crass consequence of) course (crass consequence of):				
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physiclan/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
rds, P	quires that n signed b uld be deta	ed by Pl	Part II. Other significant conditions contributing to death but not resulting in the ∓ 4 + CV ≤ h h a   Y u u q 2 / S ∈	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	
I Reco	The law require ate has been sig page 2 should b	Completed by			24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
Division of Vital Records,	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	To Be	25. Was case referred to medical examiner?  1				nAssisi heure
Divisi	al or Attar after dea Diractor d in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	ul Route Number,
	a Hospit 24 hours 1e Funara letely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and place, the occurrence of the occurrence of the occurrence of the occurrence of the occurrence of the occurrence of the occurrence of the occurrence of the occurrence of the occurrence occurrence of the occurrence occurr	and due to the cause ed at the time, date a	e(s) and manner as s and place, and due to	tated. o the cause(s)
	To the virthing comp	¥	29b. Signature and title of certifier  Wally Clar udle M5	29c. License number D3 20 1 9	1/-	Date signed (Month,	
Į.	INT		30. Name and address of person who completed cause of death (Item 23a) (Type WATA SAME AND A 106 MI) 1  31. Date filed (Month, Day, Year) JAN 15 2004  32. Registrar's Signature G	POLD St 504B	. Galisbu	iny Mb	4804
	Sta Registi		31. Date filed (Month, Day, Year)  JAN 1 5 2004  32. Registrar's Signature	Sports			

		1 - For State Registrar  1. Decedent's Name (First, Middle, Las	State of Maryland	•	irtment of I tificate of			g. No. 2004	03   06	
Physic /Medi		Douglas Charles	Jones				January	7, 2004	8:11 a <sup>M</sup> n	
Exami		4a. Facility Name (If not institution, give				or Location of Dea	ath	4c. County of Death		
		24531 Blackiston  5. Social Security Number 6. Se		t hirthday)	If Under 1 Year	11ywood	s. 8. Date of Birth		Mary's  place (State or Foreign	
Funeral Director			<b>X</b> M 2□F 60	Yrs.	Months Days	Hours Mir		Year) Con	h Dakota	
rylani show	_	10a. State 10b. County	10c. City, T	own or Loc	cation				10d. Inside City Limits	
ind in yield to the first of th	Directo	Maryland   Saint Ma	ry's Holl	ywood	7				1 Yes No	
	급	10e. Street and Number	a Dood		10f. Zip Code		10	g. Citizen of What Co	untry?	
	Funeral	24531 Blackiston	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📆 No		20636  Was Decedent of Hispanic Origin? (Specify Yes or Nof Yes, specify Cuban, Mexican, Puerto Rican, etc.)  □ Yes 2 No Specify:			No-  14. Race - American Indian, Black, White, etc.  Specify:  White		
	þ	1 □ Never Married 2 □ Married 3 □ Widowed 4 🏋 ivorced								
	Completed	15. Decedent's Ed (Specify only highest grades)	ucation 1 de completed)  Coflege (1-4or 5+)	(Give I	ent's Usuaf Occup kind of work done DO NOT use retire	during most of we	orking	6b. Kind of Business/l	ndustry	
d will	Com	12th Grade	3310g5 (1 437 5 V)	Rad	io Stati	on Manag	ger	Communica	tion	
be filed ntal Hygid of other	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, N	faiden Sumame)		
should I	P	George Ervin Jon					ne Hoagla			
Me 2 allth ar 27 is r trau		19a. Informant's Name/Relationship (7  Troy A. Jones /  20a. Method of Disposition	Son	245			Road Holly	City or Town, State, Z.  wood, Mary  Oc. Location - City or 1	land 20636	
Pages 1 nent of H int: If ite		1 ☐ Burial 2 ★ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	etery, crem	natory or other pla	1	3	,		
mit. Pages 1 a partment of Her portant: If item y injury or othe		21. Signature of Funeral Service Licen:			d-Echols			harlotte H Funeral Ho		
Depa Depa Impo any ic		Flull D.	1 Amos					runeral no ardtown, M		
Physician /Medical		23a. Part1. Enter the disease, or being shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a SMACE CE	CC (		ng, such as cardia	ac or respiratory arre		Approximate Interval Between Orget and Death	
death certificate be executed the attending physician and tor use as the burial-transit	cal Examiner									
	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal de: 4   Pregnant at time of death 9   Unknown	ath 3	Ectopic pregnancy Other (specify)	у		23d. Date of delin	very Day Year	
w requires that the been signed by the should be detached		Part II. Other significant conditions of	entributing to death but not resulting in the underlying cause given in Part I.			23e. Did tob	tobacco use contribute to the cause of death?  Yes 2 \( \subseteq \text{No} \) 3 \( \subseteq \text{Probably} \) 4 \( \subseteq \text{Unknown} \)			
	Completed						24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of	
		OF Man and referred to medical					1 ☐ Yes 2	No 1 ☐ Yes	2 □ No	
Physician: The la r this certificate has iral director, page 2	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpation	3 DOA Oth	ar	eath (Check only one		<b>4.</b> (	
g Physical chis	H-	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred							
nding fith.	tlor	1 X Naturaf 5 ☐ Pending 2 ☐ Accident investigation								
DIVISION OF VICES  - Hospitel or Attending Physician: 7 24 hours after death Funerel Director: After this certificat etely filled in by the funeral director, p	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: Atter this certifical completely filled in by the funeral director.	edical C									
To the within 2 To the complet	Me	29b. Signature and title obcertifier			29c. Licens	e number	29	d. Date signed (Month,	Day, Year)	
100		I okul B	ennett vino		Doo	19052		1/8/0	4	
IA		30. Name and address of person who o						S 5 0		
		23263 By the	mill Rd C	alife	ornia,	mD	20019			
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		South					

State of Maryland / Department of Health and Mental Hygiene

Registrar

JAN 20 2004

			For 1_ State	State of Maryland / De	partment of Health and	Mental Hygi	2001.	02100		
			1 - State Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of Death	2. Date of Death	J. No. ∠ U U 4	3. Time of Death		
	Physici /Medic		Amos Jones Jr.			January		2355 M		
	Examin	er	4a. Facility Name (If not institution, give s Anne Arundel Med		4b. City, Town, or Location of Deat Annapolis	h	Anne Ar			
	Funeral Director		5. Social Security Number 2.17-20-2262 6. Sex 1X M 2 F 7. Age (In yrs. last birthday) 1f Under 1 Year 1 Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Count Aug 18 1926 Mary							
e, Maryla	ryland thow	<u>.</u> 1	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town o	r Location			10d. Inside City Limits		
	he Ma	ecto	Maryland Anne Ar	undel Mayo	10f. Zip Code	100	g. Citizen of What Cou	iXIX es 2 □ No		
	23a or 3	Funeral Director	1209 Shesley Rd.		21106		USA			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Example art must be notified at ance.	þ	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 1950-52	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1  Yes   Yes No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: B1a	, etc.		
	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation 16a. De completed) (G	ecedent's Usual Occupation live kind of work done during most of wo le. DO NOT use retired)	rking 16	6b. Kind of Business/Ir	ndustry		
	iene.	Completed	Elementary/Secondary (0-12) 10th	College (1-4or 5+)	Custodian		aval Acad	demy		
	uld be filed Aental Hygiarked other tilc svent, I	To Be C	17. Father's Name (First, Middle, Last)  Amos Jones Sr.  Annie Tenes							
	nd 2 sho lith and 1 27 is ma r traume		19a Informant's Name/Relationship, (Type, Print) John Forrester (Grandson)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 F Bens Dr. Annapolis, Md. 21403							
	Pages 1 au nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	cemetery.	sposition (Name of crematory or other place) teran Cemetery 1	,	c. Location - City or T			
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service License	e M00483	Wm. Reese & Son 821 West St. An	s Mortua	ry, P.A.	01		
34.	Physician /Medical Examiner	16	shock, or heaft failure. List only on the thing of the th	r complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate						
Vital Records, P.O. Box 68760, sicien: The law requires that the death certificate be executed	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last  Due to (or as a consequence of):  d.							
	death certif e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1				23d. Date of delivery Month Day Year			
	uires that It signed by d be detac	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco us					use contribute to the cause of death?		
	The law requir ate has been si page 2 should	Completed				24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of		
ital		BeC	25. Was case referred to medical		26. Place of Dea	1 Yes 25 ath (Check only one)	BNo 1 ☐ Yes	2   140		
n of	ys d	မ	1 195 2 NINO	Hospital: 1   Inpatient 2   EP/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)						
	ding F. h. After funer		27. Manner of Death  1 Manual 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work?			28d. Describe how injury occurred			
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Hospita 24 hours Funeral etely filled	edical C								
)	To the I within 2 To the I complet	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)							
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Ty Saum 134 Out	pe, Printitle Rd Wes	+ River	MD 2	0778		
0	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Social s					

		1 - For Amend Item #18	State of Maryland per fh G828	1 / Depa 2 <b>/ 1.0 /</b> (	irtmen Hicat	t of Hea of De	Ith and M ath	ental Hyg	iene <sub>eg. No.</sub> 2 (	004	03109
(b)at		Decedent's Name (First, Middle, Last)						2. Date of Deat Month		Yeer	3. Time of Death
Physic		Ruth Marguerite	Johnson					Jan.		2004	9:10 p M
/Medi	W	4a. Facility Name (If not institution, give str			4b. City,	Town, or Loc	ation of Death		4c. Count	y of Deeth	
Exami	ier	240 Charita Way				Seve	erna Pai	ck	Anr	ne Ari	undel
THE STATE OF THE S		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under	1 Year If t	Under 24 Hrs.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign intry)
Funeral Director			v 2対F 74	Yrs.	Months	Days H	ours Min.	Dec. 15	,1929		MT
b		Usual Residence of Decedent									10d. Inside City Limits
ylan		10a. State 10b. County		, Town or Lo		******	Dorde				1 ☐ Yes 2 € No
B-1-8	ctor	MD Anne Ar	nuaer			verna 1	Lark			110	
th the	Director	10e. Street and Number			10f. Zip			1	I0g. Citizen of		untr <b>y</b> ?
th wi		240 Charita Way				2114			144.5	USA	in a ladia
atter death with the Marylan or Itams 23e or 28e-1 show It in entitiest be notified at	Funeral	11. Marital Status	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>	S. 13. V	Was Deced f Yes, spec	dent of Hispar cify Cuban, M	nic Origin? (Spe lexican, Puerto i	ecity Yes or No- Rican, etc.)		ack, White	
or it		1 ☐ Never Married 2 ☑ Married	1 ∐ Yes 2 🔀 No If Yes, Give		1 □ Yes	2₩ No Si	pecity:		Spec	ify:	White
OUGS the Maryland hours after death with the Maryland tural; or Itams 23a or 28a-1 show all Exert in intrinat be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	16a Docco	ient's Herr	al Occupation	1	1	16b, Kind of	Business/l	ndustry
72 l	ete	15. Decedent's Educa (Specify only highest grade	completed)	(Give	kind of wo	rk done durin	g most of worki	ng			,
withir Ithen	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4				ation S	pec.	Edu	ıcati	on
Maryiand 21215-UU30 d 2 should be filed within 72 hours af lith and Mental Hygiene. 77 Is marked other than "natural", or traumatic event, tra Medical Entra		17. Father's Name (First, Middle, Last)	-			18.	Mother's Name	(First, Middle,	Maiden Suma	me)	
d be	9 Be	John Lee Hyde				<del>-∀</del>	icta Vi	ctoria <del>ctora M</del>	yhre		
Maryland Z1Z15-UU50 d 2 should be filed within 72 hours afte th and Mental Hygiene. 77 is marked other than "natural", or it traumatic event, tra Medical Englan	2	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address			I Route Numbe		n, State, Z	ip Code)
Ma d 2 s th an 7 is r traur		Aaron Stanley Joh	. ,		-			rna Parl		2114	_
		20a. Method of Disposition	20b. P	lace of Dispo	sition (Na/	me of		Date	20c, Location		
Baltimore,  bermit. Pages 1 ar  Department of Hea  mportant: if Item:  Iny injury or other		1 ☐ Burial 2 【Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, crer letro (			Jan.		Baltin	oro	MD
it. Partmentant		21. Signature of Ameral Service Licenses				nd Address of		2004 —	Daici	ore,	I <sub>4</sub> ID
Derm Depa Impo		10/3	11.	E	3arrai	nco &	Sons. P	.A. Seve	erna Pa	rk F	uneral Home
		23a. Pagit. Enter the disease, or complice	ations that caused the death	n. Do not ent	er the mod	DV RI	uch as cardiac	or respiratory and	rest,	ICK,	Approximate Interval Between
7		shock, or heart failure. List only one	e cause on each line.		rd.	-					Onset and Death
Physiciar /Medica		disease or condition resulting in death)		COM	H						YRS
Examine			Due to (or as a consequence	uerice of):							
* **	0	Sequentially list conditions, if any, leading to university	Due to (or as a conseq	uence of):							
ted	Examiner	cause. Enter Underlying Cause (Disease or injury									
), )xecu ) and al-tra	xar	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):							
58760, icate be executed physicien and s the burial-transit											
687 tifficate g phys	adic		325-0								
<b>—</b> — ⊙ ∞	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23	Sc. If yes, outcome of pregna		7				23d. [	Date of deli	
Box eath cert attendin I for use	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		∃Ectopic p ∃ Other (s <sub>i</sub>					<b>Jonth</b>	Day Year
	lysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown								
ecords, P.O law requires that the as been signed by th		Part II. Dther significant conditions con	tributing to death but not res	ulting in the u	ınderlying	cause given i	in Part I.	23e. Did to	obacco use co	ntribute to	the cause of death?
ds, uires t signe	d by							101	res 2□No	3 □ Pr	obabiy 4 Unknown
Division of Vital Records, to Attanding Physician: The law requires tatler death.  Director: Atler this certificate has been signe in by the funeral director, page 2 should be.	Completed							24a. Was		o. Were au	topsy findings available
Rec ne lav	dm								rmed?	death?	completion of cause of
al Re n: The l icate his r, page						0.0	e Diago of Da-4		2000	1 🗌 Yes	2□ No
of Vital Physician: This certifical	Be	examiner?	ospital:	ED/Outpation	nt 3 D	Other		h <i>(Check only o</i> ome 5 ≿(Hesio		other (Sna	cifv)
Phys Phys	<u>2</u>	1 Yes 2 TNO	1   Inpatient 2	28b. Time of		28c. injury at		28d. Describe I			//
Jing J After funer	on	1 Satural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	Injury	м	Work?	s 2 🗆 No				
Vision Attending If death. ector: Atte	icat	2 Accident 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, st	reet, facto					mber or Ru	ural Route Number,
Division of Attended the Attended to Director:	Certification;	4 Homicide determined	building, etc. (Special	(y)		• 1		City or To	wn, State)		
Division of Vita To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.			sician: To the best of my kno	owledge, dea	th occurred	d at the time,	date and place,	and due to the	cause(s) end	manner as	stated.
e Hospitel 24 hours Funeral	edical	(Check only 2 Medical Exemile one)	er: On the basis of examina and manner stated.	ation and/or in	nvestigatio	n, in my opini	ion, death occur	red at the time,	date and plac	e, and due	to the cause(s)
To the within 2 To the complet	Me		11		29	9c. License n	umber		29d. Date sig		
⊢≱⊨S		1/1 Man	Ky MA			DI	8281	7	JAN	19	2004
		30. Name and address of person who co	impleted cause of death (Ite	m 23a) (Type	Print)		/	C.			
		30. Narre and address of person who co	1-1 9/1	7)	ATON	) Ai	E	BALTI	MURE	M	2004
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	100	, , , ,					/
	strar	IAN 0 1 20	104 Mining	K	Someth	60					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Deta of Deeth 3. Time of Death Month Day Yea **Physician** Joseph P. Jackson 8:00 PM 4b. City, Town, or Location of Daath 16, 2004 /Medical 4c. County of Deeth 4a Facility Name (If not institution, giva straat and number) Examiner Rising Calvert Manor Healthcare Center Sun Cecil If Undar 1 Yaar Birthplaca (State or Foraign Country)

PA 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 6. Sax Data of Birth (Month, Day, Yaar) Funeral Days 1**⊠**M 2□F Hours Min. Months 186-14-7087 Director 4-3-1920 Usual Rasidence of Dacedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene "important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be nothered at 10c. City, Town or Location 10a. Stata 10d. Insida City Limits 10b. County PA Chester Nottingham 1 Yas 2000 **Funeral Director** 10f. Zip Code 10e. Straat and Number 10g. Citizan of What Country? 185 Cemetery Road 19362 USA 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, 12. Was Dacedant Evar in U,S. Armad Forcas? 11. Marital Status Black, Whita, atc. 1 Navar Marriad 2 Married ☐ Yas 2 No Yas. Giva Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: Completed by If Yas, Giva Yaar or Datas: White 3 Widowad 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Agriculture 12 Farmer 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Surnama) Be Charles Jackson Jenney Phillips 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Richard E. Jackson 50 Glen Roy Road, Nottingham PA 19362 20b. Place of Disposition (Nama of camatery, crematory or othar placa) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Nottingham Cemetery 1/20/04 Nottingham, PA 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Euneral Sarvice Licenses 22. Nama and Addrass of Fecility Edward L. Collins Funeral Home, Inc. 86 Pine Street, Oxford PA 19363 23a. Pert1. Enter the diseasa, or complications that causad tha daath. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disaasa or condition rasulting in daath) /Medical neumonia Examiner Due to (or as a consequence of): Physiciar/Medical Examiner 2-3 month chasis attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaase or injury that initiated events rasulting in daath) Last Dua to (or as a consequance of): Division of Vital Records, P.O. Box 68760 Dua to (or as a consequence of) signed by the all Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uee contribute to the cause of death? 1 ☑ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Side Sinus SANGROME à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1LIYSS ZENO 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residanca 6 Othar (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred After 5 Pending invastigation 1 Natural To the Hospital or Attanding within 24 hours after death.

To the Funerel Director: After completely filled in by the fun 1 ☐ Yas 2 No 2 Accidant 6 ☐ Could not ba determined 3 Suicida Location (Straat and Numbar or Rurel Routa Numbar, City or Town, Stata) 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a. Cartifier (Check only 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the causa(s) and manner as statad.

2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. Medical 29b. Signatule and title of certifian 29c. Licanse number 29d. Date signed (Month, Dey, Year) 2004 MW complated cause of death (Item 23e) (Type, Print) Rising Sun Maryland 21911 101 Colonial Way

**DHMH 16 Rev 6/95** 

State Registrar 32. Ragistrar's Signature

State Registrar Day, Year) 1 4 2004 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 07 Month **Physician** 04 01 Johnson 12:55P™ Kim /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince Georges Medical Center Prince Georges 8. Date of Birth (Month, Day, 03 04 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Yrs. 579-94-9122 35 **Director** Washington, D.C. Usual Residence of Decedent wor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at Director 1- Yes 2 No Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10729 Campus Way South 20774 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2K No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) jes 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 Is marked other than "r or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 10th, Homemaker Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Mathis Doris Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or othar traun 10729 Campus Way So. Upper Marlboro, Md. 20774 Kimberly Johnson Daughter Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Glenwood Cemetery N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1-13-04 Washington, D.C. 22. Name and Address of Facility Marshall's Funeral HOme 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 Marchall 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Melimania /Medical resulting in death) Due to (or as a consequence of): Examiner well Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and I-transit death certificate be executed Due to (or as a consequence of): anding physician a use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ŏ Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f ☐Yes 2X No 9 Unknown 9 Unknown s been signed by t should be detach The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Avenua Wilhary touch untection 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? of Vital I 1 🗌 Yes 2 X No Attending Physician: ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 ☐ Yes 2 🖺 No 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide Hospital completely filled 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of a rtifier 29c. License number 58322 leted cause of death (Item 23a) (Type, Print) Prince George's Hospital 3001 Hosp. DR. Cheverly Mel. h05/a hikha 31. Date filed (Month, Day, Year) State 2004 **JAN 15** Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1531 M JANUay 2004 JACKSON 51 AT.MA /Medical County of Deeth 4e. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner WAShing Fout 2 10m Wash Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey. 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 1922 SOUTH CAROLINA Director 577 02 5988 Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show odcal Examiner must be notified at XXYes 2 No Director FORT WASHINGTON MARYLAND PRINCE GEORGES 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number UNITED STATES OF AMERICA 20744 Funeral 13000 JACKSON DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 Tho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Examinariance. 1 Never Married 2 Married 1 Yes XXNo Specify Specify: BLACK à Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9TH HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CHARLES HOLLOWAY ROSABELL WIDEMAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FT. WASHINGTON, MD 20744 13000 JACKSON DRIVE ROBERT JACKSON (SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition XXBurial 2 Cremation 3 Removal from State 01/15/2004 LANDOVER, MARYLAND HARMONY MEMORIAL PK. \* 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Aicensee 22 Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC.
4308 SUITLAND ROAD SUITLAND, MD 20746 aw Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final حر **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MOTOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the th attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months?
1 Yes 2XXVo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2. No 3 Probably 4 Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed certificate 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examinar? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXInpatient 2 ER/Outpatient 3 DOA Certification; To (his 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred BACK 5 200 27. Manner of Death 28c. Injury at Work? After t PASS ENGL 1 Natural 5 Pending investigation 2 2 No 10:00M 1 TYes accident 2 Accident 2003 in the Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 0 Brun ford ~ ation within 24 hours a To the Funeral L 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 SALMON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 5 2004 Registrar

**ORIGINAL** 

			i icase i	State of Man			t of Health and		_	•
			1 - For State Registrar	Clate of Mary	-	•	of Death		g. No. 200	4 03/15
			Decedent's Name (First, Middle, Last)	)	-			2. Date of Deat	1	3. Time of Death
	Physici /Medi		Martin .	Julius	Knott	:		January	2, 2004	10:05 a.M.
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Location of De	ath	4c. County of De	
		2,	St. Mary's Nurs				Leonardt			Mary's
r	Funeral		5. Social Security Number 6. Security Number 1		n yrs. last birt	hday) If Under Months	1 Year If Under 24 H Days Hours Mi	n. (Month, Day,	Yeer) 9. B	inhplace (State or Foreign Country)
	Director		Usual Residence of Decedent	<sup>2M 2⊔ F</sup>   76		13.		July 8,	1927   Ma	ryland
	yland		10a. State 10b. County	10	Oc. City, Town	or Location				10d. Inside City Limits
	a-f el	ctor	Maryland St. Mary	y's			Ridge			1 ☐ Yes 2 € No
	or 28	Director	10e. Street and Number			10f. Zip	Code	10	g. Citizen of What C	Country?
	hours after death with the Maryland turel', or Items 23s or 28s-f show at Exacidiner; tast be nutified at		13315 Point Looko		_		20680		nited Sta	
	er de	Funeral		12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Deced If Yes, spec	ent of Hispanic Origin? ify Cuban, Mexican, Pu	(Specify Yes or No- arto Rican, etc.)	14. Race - Am Black, Wh	
36	irs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:		1□Yes 2	No Specify:		Specify: Wh	ite
51215-0036	72 hours after death with the Marylan *natural; or Items 23a or 28a-f ehow calcal Exampler; and be notified at	ted	15. Decedent's Edu	ıcation	16a.	Decedent's Usua	I Occupation	1	6b. Kind of Busines	s/Industry
22	within 72 ene. than na	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of wor life. DO NOT us	k done during most of w e retired)	rorking		
	be filed within 72 ho ital Hygiene. d other than "natureseent, the Miculcal	Completed	12		Pi	pe Fitte			Civil Ser	vice
	be fill d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, M	aiden Sumame)	
<u> </u>	should by	2	Martin Webster I		401	** **		th Elizabe		
Maryland	d 2 sho		19a. Informant's Name/Relationship (Ty)				(Street and Number or I		•	Zip Code)
ē,	s 1 and 2 should f Health and Men item 27 le marke other traumatic	133	Eunice I. Knott / 20a. Method of Disposition		P. 20b. Place of	O. BOX 2 Disposition (Name of crematory or of	205, Ridge,		20680 0c. Location - City o	r Town. State
ᅙ	Pages nent of int: If it		1  Burial 2  Cremation 3  R  ¹ 4  Donation 5  Other (Specify)	Temoval Irom State					•	
Baltimore,		7	21. Signature of Euneral Service License	-	111111	y Episco 22. Name and	*	.6,2004 5t		Home, P.A.
ñ	permit. Departi Import any inj	2.0	Edward N. Brinsfie	ld, Ji. MC	00052					20650-0279
\$5 5	\$ <u>}</u>		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused the	death. Do n					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pula	A 7. 0	=	/2			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence o	f): /				
	LAdimies	<u>.</u>	Sequentially list conditions,	o. Renal	fa	ilure	)			
	bed nsit	Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	ปกรษนุษษาเดอ ป	7.				
	be executed ician and burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a co	onsequence o	f):				
09/	eath certificate be executed attending physician and for use as the burial-transit	call		d						
Q	certificate Iding phys Ise as the	ledi	Les Services							
X Q Q	th cer tendir r use	Physiclan/Med	230. Was decedent pregnant	23c. If yes, outcome of p		3 □Ectopic pre	onancy		23d. Date of de	,
7	e death the atten	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time 9☐Unknown		5 Other (spe			Month	Day Year
7.	w requires that the death been signed by the atte should be detached for	Phy	Part II. Other significant conditions con	ntributing to death but n	ot resulting in	the underlying ca	use given in Part I	23a Did tobs	con usa contributa t	o the cause of death?
as,	signe d be	d by	42 4	1 1 *	Pal	and and onlying ca	Are			robably 4 Junknown
ecoras	v requ	ompleted	( 1	1	1	1	acrase	-		
Ē	icien: The law certificate has b ector, page 2 st	dmo	Cerela Oralus C	as the	dem	0		24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
N I I I	en: T	e Co	25. Was case referred to medical	c.=			26 Place of D	1 □ Yes 25		3 2 □ No
		0	examiner?	lospital: 1 ☐ Inpatient	2 ER/Out	patient 3 DO	0.4	eath <i>(Check only one)</i> Home 5 Residen		acihi)
0	ding Phys h. After this funeral di	T:u	27. Manner of Death	28a. Date of Injury (Month, Day Ye			ic. Injury at Work?	28d. Describe how		iony)
0	endir sath. or: Af he fur	atio	1 Natural 5 Pending 2 Accident investigation	(		M	1 ☐ Yes 2 ☐ No			
UNISION	or Attentiter deat irector: n by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, fari Specify)	n, street, factory,	office	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
_	pitet urs ai eral D		CO. Cartilla ASS Cattains Store	lei - Tarkaban (a				1		
	To the Hospitet or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medicel Examir one)	sician: To the best of m ner: On the basis of exa and manner stated.	amination and	death occurred a or investigation,	t the time, date and plac in my opinion, death occ	e, and due to the cau surred at the time, dat	se(s) and manner a: e and place, and du	s stated. e to the cause(s)
	ro the round of the complex co	Me	29b. Signature and title of certifier			29c.	License number	290	I. Date signed (Moni	th, Day, Year)
	. 250		DARA	MD			D56261	1	-5-2004	
			30. Name and address of person who con	mpleted cause of death	(Item 23a) (T	ype, Print)	D2020I	1	-3-2004	
			Archana Gupta, M.			Notch Ro	ad, Hollywo	ood, Maryl	and 20636	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Acel				
		-10	JAIT	Luy Ballet	1000	0				

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** January 3, 2004 9:00 AMM Marion **Gladys** Kinsler /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's Bayside Care Center Lexington Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Yrs Dec. 4, 1919 Pennsylvania 258-05-3282 Director 84 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-1 ahow event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Lexington Park Maryland St. Mary's Directo 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? WITH permit. Peges 1 and 2 should be filed within 72 hours atter death 1 Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a any injury or other traumatic event, the Medical Examples must once. 21412 Great Mills Road 20653 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Mellon Sq. Garage 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Mary Mucha 2 Franklin Gever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barb Williams Granddaughter 1516 Berkshire Ave., Pittsburgh, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State 01-07-2004 Pittsburgh, PA Resurrection \*4 □ Donation 5 □ Other (Specify) 21. Signature Peral Series Edward N. Brins 22. Name and Address of Facility Brinsfield Funeral Home, P.A Brinsfield, Jr. Leonardtown, Maryland 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Freum anda Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physicien and had for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Pe 3 Probably 4 Unknown cate has been sig page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 ☐ Yes 2₽No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Injury after death.

Director: Af
d in by the fur investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel D To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D5626 20436 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) da chana MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 6 2004 Registrar

ADH BARBARA JEAN KENNEY 04-0430

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

J4.	30		For	State of	of Marylar	•	artment of H		Mental Hy	giene	m m 1	
			State Registrar			Cei	tificate of	Death		Reg. No.	UUL	03117
	Physicia	25	1. Decedent's Name (First, Midd	le, Last)					2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al .	BARBARA JEAN K						JANUAR		2004	1840 P <sup>™</sup>
	Examin	1.00	4e. Fecility Name (If not institution 30970 OLD FRUIT	-			•	r Location of Deat	h		nty of Death	
			5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	FRUITLAN If Under 1 Year	ND If Under 24 Hrs	8. Date of Bir	th	9. Birtho	lece (State or Foreign
	Funeral Director		219-56-8637	1 M 2 XF	53	Yrs.	Months Days	Hours Min.	09-18-	1950	KANS	AS
è			Usual Residence of Decedent									
	how		10a. State 10b. County	,		ty, Town or Lo					1	0d. Inside City Limits
	e Ma	cto	MD WI	COMICO	SAI	LISBURY						1 ☐ Yes 2X☐ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o		ntry?
	s 23s		30970 OLDE FRU		AD sedent Ever in U	10 12	21804 Was Decedent of H	Jiangaja Origin? /6	Constru Van or No		USA ace - Americ	ean Indian
	iter de	Funeral	11. Marital Status  1 ☐ Never Married 2X Mar	Armed F	orces? 2 🔯 No		f Yes, specify Cubi	an, Mexican, Puer	to Rican, etc.)		tack, White.	
336	hours after death with the Maryland tural; or Items 23s or 28s-f show al Expirerer must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	ive		1□Yes 2█No	Specify:		Spec	eify: WH]	TE
Ö	wihin 72 hours after death with the Marylan iene. rthan "natural", or ftems 23a or 28e-f show the Medical Examinat must be notified at	Completed		nt's Education est grade completed;		16a. Dece	dent's Usual Occup	ation during most of wo	rkina	16b. Kind of	Business/In	dustry
215	within 7 ene. than "r	nple	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT use retired	d)	ining	CELE	EMDI OX	7.F.D.
2		Co	12	10		HA	AIRDRESSE	r	me (First, Middle	1	EMPLOY	ED
Maryland 21215-0036	0 0 0	Be	17. Father's Name (First, Middle, RAYMOND BRADFO						HAMAKEF		ame)	
7	should be ind Mental is marked o	우	19a. Informant's Name/Relation			19b Mailir	ng Address (Street				m. State. Zic	Code)
Ma	12 h 8 7 h tra		HOWARD KENNEY									LAND 21804
	s 1 and 2 f Health Item 27		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place	cel	Date	20c. Location	n - City or To	own, State
OE	0 0		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (				OF DELM		17-2004	DELMAR	, DELA	AWARE
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of F meral Service	Licensee	20		2. Name and Addre					
Ö	Pe a m a d		1 len	W 3	Kell						MARYI	LAND 21804
			23a. Pert1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	each line.				_	rrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):	,					
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	ited Insit	ulu E	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>{</b>	`							
Ć,	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a consec	quence of):						
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9	rtifica ng ph as th	Med	IF FEMALE:									
Вох	leath certifica attending ph I for use as t	an/I	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregn birth 2 Pet	al death 3	Ectopic pregnanc	у		1	Date of deliver	ery Day Year
O.	at the dea by the at tached for	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☑ Inknown	4∐Preg 9☐ Unki	nant at time of a nown	death 5	Other (specify) _					,
0	that the		Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	tobacco use co	ontribute to t	ne cause of death?
Records,	uires tha signed I	d by							10	Yes 2□No	3 🗆 Prot	ably 4 Unknown
COL	w require been sig should b	lete							24a. Was	an 24t	o. Were auto	psy findings available
Re	he lav e has age 2	Completed								psy ormed? 2 \( \subseteq \text{No} \)	death?	mpletion of cause of 2∏ No
Vital		a)	25. Was case referred to medic	al				26. Place of De	ath (Check only o		× 33	20.10
Į V		To B	examiner? 1 → Yes 2 □ No	Hospital: 1	Inpatient 2	ER/Outpaties	nt 3 DOA Ott	ner: 4 🗌 Nursing i	Home 5□Resi	idence 6XC	ther (Specif	AT SCENE
n of	50 0 0		27. Manner of Death 1 □ Natural 5 □ Pend	ing 28a. Date	of Injury nth, Day Year)	28b. Time o Injury	Wo	rk?	28d. Describe	how injury occ	urred C Coll	
sio	Attending Pher death. ector: After they they they they they they they they	catl		tigation Figure	415104	Fred 183	11.45	Yes 2 No	verje c	1 good	3	- Courte March -
Division	or At after d Direct in by	Certification:	4 Homicide deter	minord 200. Flat	ding, etc. (Spec	ify)	reet, factory, office		City or To	wn, State) 30	\$70 PC	Route Number,
ш	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 ☐ Certify	ing Physician: To th	e best of my kn			me, date and plac	e, and due to the	cause(s) and	manner as s	tated.
	24 hose Fun	Medical		Examiner: On the								
	Fo th within Fo th	Me	29b. Signature and title of certifi	er			29c. Licens			29d. Date sign		
			Medda	U.K.	× m	2		OCME		JANUA!	кл 16	, 2004
A 7	Ø,		30. Name and address of perso	n who completed cau	of death (Ite							
0]	N.		THEODOREM	King			Penn Sta	reet, Bal	timore,	Maryla	nd 21	201
	Sta Regist		31. Date filed (Month, Day, Yea	n 2004 32.	Registrar's Sign	nature &	Soon	6				
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				For 1 == Stete Registrar	State	of Maryla	-	artment of rtificate o		d Mental Hyg	iene	304	03118
		Dhusisi		Decedent's Name (First, Middle, L.)	ast)					2. Date of Dea		Year	3. Time of Death
•		Physici /Medio		John C. Kni				45 C/2 T	1	January	2	2004	12:01 A <sup>M</sup>
	4	Examin	er	4a. Facility Name (If not institution, gas Suburban Hos		um ber)		4b. City, Town	n, or Location of Do Bethesd		4c. Cour	nty of Death	gomery
		Funeral			Sex	7. Age (In y	rs. last birthday)		ear If Under 24 h		Vear		place (State or Foreign intry)
		Director		212-54-4729	1 <b>⊠</b> M 2□F		77 Yrs.	Months Da	ys Hours IV	June 16			otland
		and and		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or Le	ocation					10d. Inside City Limits
		Mary If sh	ţō	District of C	olumbia			Was	hington				1X∏Yes 2 □ No
i		th the or 282 e not	Jirec	10e. Street and Number	<u> </u>			10f. Zip Cod		1	0g. Citízen o	of What Cou	intry?
		ath w	rai	3403 Fessende					20008				States
		ter de Items	Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed F	cedent Ever in forces? 2 📉 No	1 U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Origin? Cuban, Mexican, Po	(Specify Yes or No- uerto Rican, etc.)		ace - Ameri lack, White,	
	920	ours after death with the Marylan ral', or Items 23a or 28a-f show Examiner must be notified at	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or	ive		1 ☐ Yes 21💢	No Specify:		Spec	cify: Wi	nite
	altimore, Maryland 21215-0036	2 should be illed within 72 hours after death with the Maryland and Mental Hygiene. Is marked othar than "natural", or Items 23a or 28a-f show raumatic evant, the Medical Examiner must be notified at	Completed	15. Decedent's l (Specify only highest g	Education rade completed	")	(Give	dent's Usual Oc	ne during most of	working	16b. Kind of	Business/Ir	ndustry
	121	within ane. than	mpi	Elementary/Secondary (0-12)	-	(1-4or 5+)	life.	DO NOT use re	1103			_	
	<b>d</b> 2	filed Hygie othar ant, II		17. Father's Name (First, Middle, Las		6		Pn	nysicist 18. Mother's	Name (First, Middle, I		Goveri ame)	ment
	/an	uld be Aental rked (	To Be	J. T. Kni	ght					Unk	nown		
	lary	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev once.		19a. Informant's Name/Relationship						Rural Route Number			
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	B.	death e atter id for u	iciar	in the past 12 months?	4□Preg	birth 2 □ Fo nant at time o		⊒Ectopic pregna ⊒ Other (specify				Month	Day Year
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000	Division of Vital Records, P.O. Box	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	by	Part II. Other significant conditions  MitRM MALVE		death but not i	resulting in the u	inderlying cause	given in Part I.		oaccouse co es 2 □ No		he cause of death?
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112/04	Rec	The law ate has page 2 s	mpi							24a. Was a autops perform	n y ned?	prior to co death?	opsy findings available impletion of cause of
K	tal		O I	25. Was case referred to medical					26 Place of I	1 ☐ Yes 2 Death (Check only on	e)	1 🗌 Yes	2∐ No
	Ę	lysicia is cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	! ☐ ER/Outpatie	nt 3 DOA	Other	g Home 5 ☐ Reside	ALC: Vini	ther (Specia	(y)
4	0	ng Ph fter th ineral		27. Manner of Death  1. ⊠Natural 5 □ Pending	28a. Date (Mo	of Injury nth, Day Year,	28b. Time o Injury	of 28c. In	njury at Work?	28d. Describe ho	w injury occ	urred	
5	isio	Attanding Physician: or death. ector: After this certification in the funeral director.	cati	2 Accident investigati	be as Die	o of Injune. A	t home form at		I □ Yes 2 □ No	28f. Location (St	roat and thu	-has as Ow	al Pauta Alive hav
+	Div	after a Direc	Certification;	4 ☐ Homicide determine	d 259. Flac	ding, etc. (Spe	t home, farm, str ecify)	гөөт, тастогу, опп	Ce	City or Town	, State)	nuer or mura	ar moute reumber,
Kuight, John		To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying F	Physician: To th	ne best of my i	knowledge, deat	h occurred at the	e time, date and pl	ace, and due to the ca	ause(s) and i	manner as s	stated.
Z		tha Ho in 24 tha Fu ipletel	Medical	опе)	and ma	nner stated.	ination and/or in			ccurred at the time, da			
		with To 1	Σ	29b. Signature and title of certifier	n A				ense number	29	9d. Date sign	ned (Month,	Day, Year)
				Xalan /	2 1/18	92/	MIDE	VO	8115	1 771	1/2/0	4	
C	K	(5)				ulse of death (I 1/12)	tem 23a) (Type,	ille, MI)	20852	W. Edmonst	on Dri	.ve	
		Sta		31. Date filed (Month, Day, Year) JAN 1 3 2004		Registrar's Sig	gnature						
		Registr	rar	JMN 1 3 ZUU"	F 10-00	B	///	72 /					

			1 - For State Registrar	State of M	/laryland		artment of rtificate of		and Mental Hy	giene Reg. No. 200	03119
2	Physici /Medi		Decedent's Name (First, Middle, Last)     JOHN KLINE						2. Date of De Month	Day, Ye	
	Examir			e For	tel		4b. City, Town,	~ De	le	4c. County of D	Cerges
e.	Funeral Director		5. Social Security Number 6. Sex 078-12-8675	7. A	Age (In yrs. Ia 83	ast birthday) Yrs.	If Under 1 Yea Months Days		Min. 8. Date of Bi (Month, Di July 1	ey, rear	Birthplece (State or Foreign Country) EW York
	Maryland -f show	tor	10a. State 10b. County  MD PRINCE GE	ORGE <sup>1</sup> S	10c. City	, Town or Lo					10d. Inside City Limits  ☑ Yes 2☐ No
	with the 3a or 28a	al Director	10e. Street and Number 6808 HILLMEADE R			CLIII	10f. Zip Code	720		10g. Citizen of What	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Evantinar must be recilified at ance.	Completed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s? No NA	AVY   '	Was Decedent of f Yes, specify Cul	oan, Mexican	in? (Specify Yes or No Puerto Rican, etc.)		vnerican Indian, vhite, etc. WHITE
Maryland 21215-0036	d within 72 ho giene. er than "natu , the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0·12) 12th		r 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retin L DYE MA	during most	of working	16b. Kind of Busine	ess/Industry
/land	uld be file Mental Hy, irked other	To Be C	17. Father's Name (First, Middle, Last) JOHN B KLINE					18. Mother	r's Name <i>(First, Middle</i> RUTH HAF		
	and 2 sho salth and I n 27 is mu		19a. Informant's Name/Relationship (Ty, JOHN B. KLINE/SON			19b. Mailir 6808	g Address (Stree HILLMEA)	t and Number DE ROAI	r or Rural Route Numb OGLENDALE,	er, City or Town, Stat MARYLAND	e, <i>Zip Code)</i> 20720
Baltimore,	Pages 1 nent of He ant: If itan ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	e <i>ce</i>	metery, cren	sition (Name of natory or other pla E CREMA	, I	Date L-14-2004	20c. Location - City RIVERDALE	
Balt	permit. Departrimporta		21. Signature of Funeral Service License	roha	00				J. B. JEN ROAD LANDOV		
i	Physician	34.00	23a. Part1. Enter the disease, of complishock, or heart failure. List only or Immediate Cause (Final disease or condition						fardiac or respiratory a		Approximate Interval Between Onset and Death
and the	/Medical Examiner	ner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or a	s a consequ	ence of):					
8760,	icate be executed physician and if the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a conseque	ence of):					
O. Box 68	ne death certif the attending thed for use as	by Physician/Med	IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcom 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3□	Ectopic pregnand	ey .		23d. Date of Month	delivery Day Year
rds, P.	quires that the signed by aid be detacted		Part II. Other significant conditions con	tributing to death	but not resul	lting in the ur	nderlying cause g	ven in Part I.			e to the cause of death?
Il Records,	: The law require cate has been si page 2 shouid i	Completed								ormed?death	autopsy findings available to completion of cause of ? 'es 2 No
Division of Vital	Attending Physician: The Ir death. ector: After this certificate haector: After this certificate haby the funeral director. page	ation: To Be	25. Was case referred to medical example?  1 Yes 2 No  27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1	tient 2 □ E jury jay Ye <i>ar)</i>	P/Outpatien 28b. Time of Injury	28c. Inju	her: 4 🗆 Nur			(pecify)
Divis	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inbuilding, e	njury - At hor etc. <i>(Specify)</i>	ne, farm, stre	eet, factory, office		28f. Location (. City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir comptetely filled in I	Medical	(Check only 21 Madical Examir one)	nician: To the bes ner: On the basis and manner s	of examination	riedge, death on and/or inv	occurred at the trestigation, in my	ime, date and opinion, death	place, and due to the n occurred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	To the I	Σ	29b. Signature and title of certifier	flagt.	20	) <b>3</b>		se number	2-7	29d. Date signed (Mo	onth, Day, Year)
7	(1)		30. Name and address of person who	mpleted cause of		23a) (Type,	Print)	we C	Level	Marylas	wd.
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 4 2004	32. Regis	trar's Signatu	иге			01		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10, 2004 10:15 PM Lillian May Lichty January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Solomons Nursing Center Solomons Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months 577-03-3222 9.5 Director January 24, 1908 Maryland Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examilier is ust be notified at once. Maryland 1 ☐ Yes 2 XNo Calvert Solomons Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1325 Dowell Road 20688 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Hooper Lynch Emma Jane Ritter 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5408 N. 37th Street, Arlington, VA 22207 Donald Herman Lichty/Step-son 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) January 15, 2004 Brentwood, Maryland Fort Lincoln Cemetery 21. Signature of Funeral Comp 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270, Leonardtown, MD 20 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oronam resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Sua to (or se a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of). P.O. Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1☐Live birth 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) by the a 9 Unknown 9 Unknown ģ signed b Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 🗌 Yes 2. No 3 Probably 4 Unknown plnous been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has I autopsy 1 ☐ Yes 2 No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification; 28d. Describe how injury occurred After 1 ☑ Natural 2 ☐ Accident 5 Pending investigation death. 1 Tyes 2 No after death Director: / d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide thin 24 hours aft the Funerel Di mpletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2

To the complete 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO 59409 MD. 222 01.13.04 30. Name and address of person we completed cause of death (Item 23a) (Type, Print)
Issa Yusuf, 37767 Market rive, Charlotte Hall, MD 30. Name and address of 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

5

Baltimore, Maryland 21215-0036

CHARLOTTE LANE

Division of Vital Records, P.O. Box 68760,

	-	For State Registrar	State of Ma		partment of ertificate of		and Mental Hy	giene Reg. No.	2004	03121
Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	aath Day	Year	3. Time of Death
/Medica	al .	CHARLOTTE ANN LA					Januar		2004	2305 M
Examine	er	4a. Facility Name (If not institution, give s			4b. City, Town				County of Death	
		MEMORIAL  5. Social Security Number 6. Sex	HOSPIT	e (In yrs. last birthda		ASTON ar If Under	24 Hrs   9 Date of Bi	rth	ALBOT	place (State or Foreign
Funeral Director			M 25 F	61 Yrs.	Months Day		Min. (Month, De	av. Year)	Cou	YLAND
	-	Usual Residence of Decedent		01			1100 10	1772	THAN	LEZND
yland		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
Mar-f st	ţċ	MD QUEEN ANN	E'S	CENTRE	VILLE					1 ☐ Yes 2 🕅 No
or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cou	intry?
th wi	ē	810 BRICK SCHOOL	HOUSE RD			1617			USA	
r dea	nel	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of If Yes, specify Cu	f Hispanic Ori uban, Mexicar	gin? (Specify Yes or No n, Puerto Rican, etc.)	0- 14	<ol> <li>Race - Ameri Black, White,</li> </ol>	
or It	by F.	1 ☐ Never Married 25€ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ If Yes, Give Year or Dates.	No	1□ Yes 2√2 N	lo Specify:		s	Specify: TJT	HITE
72 hours after death with the Maryland retural; or Items 23a or 28a-f show dical Exeminer must be notified at		15. Decedent's Educ			edent's Usual Occ	rupation		16h Kin	d of Business/Ir	
n 72	Completed	(Specify only highest grade	completed)	(Giv	e kind of work dor DO NOT use reti	ne durina mos	t of working	TOD. KIII	a 0, Dasiilossii	ladatiy
with iene ther	Eo	Elementary/Secondary (0-12)	College (1-4or !		PTROLLER			COUN	TY GOVE	ERNMENT
tifed Hyg othe	BeC	17. Father's Name (First, Middle, Last)	V -	<u>-</u>		18. Mothe	er's Name (First, Middle	, Maiden S	Sumame)	
	10 B	EARLE O. HARRISON				LEI	NA VIRGINIA	TTAW	.'S	
s ma		19a. Informant's Name/Relationship (Type	ое, Print)	19b. Ma	iling Address (Stre	et and Numbe	er or Rural Route Numb	er, City or	Town, State, Zij	p Code)
and 2 saith n 27 i		ALVIN B. LANE, JR.	/HUSBAND			CHOOL 1	HOUSE RD.			
of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	cometon, ci	position (Name of rematory or other p	lace)	Date	20c. Loca	ation - City or T	own, State
Pag ment ant: I ury o		*4 □Donation 5 □Other (Specify)	o,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	WOODLAWN	MEMORIA	L PARK	1-21-2004	EAST	ON, MAR	KYLAND
Departit. Departit Import any nj 2005		21. Signature of Funeral Service License	90	O. O. F	22. Name and Add	iress of Facilit 나타다 다당N	ly RVTN S. NVUN	M ET	MEDAT L	IOME DA
1 20 5 6 d	0 1	10594 M. E	Trough	C.F.SF 2	00 S. HAI	RRISON	ÉEIN & NEWN ST EASTON,	MD 2	1601	IOTE TA
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused se cause on each li	d the death. Do not e ine.	nter the mode of d	lying, such as	cardiac or respiratory a	ırrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition		tepatic	Insuf-	ticier	VCU			1 month
/Medical Examiner		resulting in death)	Due to (or as	a consequence of):			cancer			1.4
6.	Ų.	Sequentially list conditions, if any, leading to immediate	Due to for as	a consequence of):	itic 17	Yeast	Cancer	•		Y jiwi
ed .	Examiner	Cause (Disease or injury	D00 t0 (01 as	a consequence on.						•
be executed ician and burial-transit	xan	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
bur bur	caiE									
the state of	ed									
The law requires that the death certification has been signed by the attending phoage 2 should be detached for use as the control of the cont	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23	3d. Date of deliv	ery
death e atte	icia	in the past 12 months?	4☐Pregnant a		□Ectopic pregnar i □ Other <i>(specify)</i>		<del></del>		Month	Day Year
that the de ed by the detached	hys	9 🗆 Unknown	9□ Unknown							
res tha igned be del	by P	Part II. Other significant conditions con	tributing to death b	out not resulting in the	underlying cause	given in Part I				the cause of death?
w require been si							1	Yes 2 🗓	No 3 ☐ Prol	bably 4 DUnknown
e law r has be	Completed						24a. Was		prior to co	opsy findings available ompletion of cause of
	Com							ormed?	death?	2 □ No
ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?					of Death (Check only	one)		
	P	1 Yes 2D No	lospital:		ent 3 DOA		rsing Home 5 Res			fy)
ing P	on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time uy Year) Injury	W	ijury at Vork? □Yes 2□	28d. Describe	now injury	occurred	
ttend death tor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28a Place of In	jury - At home, farm,		-		Street and	Number or Run	al Route Number,
or A after Direc	ertification:	4 Homicide determined	building, e	tc. (Specify)	street, ractory, onic	æ		wn, State)	reamber of riam	ar riodio rambor,
spital ours neral filled	O	29a. Certifier 1 Certifying Phys	sician: To the best	of my knowledge, de	ath occurred at the	time, date an	nd place, and due to the	cause(s) a	and manner as s	stated.
To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	edical			of examination and/or			th occurred at the time,			
To th To th	Me	29b. Signature and title of certifier		^ `	29c. Lice	ense number		29d. Date	signed (Month,	Day, Year)
		M. Con	11104	SLAMA O	IT	)472	-32	1	19/20	04
		30. Name and address of person who co			rint)		-	51		
		MARY DESHIELDS M.			E., EASTO	ON, MD	21601			
Stat		31. Date filed (Month, Day, Year) JAN 2 0 2004	32. Registr	rar's Signature	al a					
Registra	ar	2004	A STATE OF THE STA	N. WOON						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Winifred C. Lion January 20. 2004 12:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 7,1917 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1 □ M 2 X F Days 578-03-1012 86 Director Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 ie marked other than "natural; or iteme 23a or 28a-f ehow 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Exams in rights by notified at 1 ☐ Yes 2 X No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1918 Ridgeville Rd. 21037 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White Specify. à 3℃Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Electrical Supply Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Thomas Johnson May King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Bennett/ Daughter 1918 Ridgeville Rd., Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Kalas Crematory 1-22-04 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home ulle 2973 Solomons Island Rd. Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 440cardia **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vast 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 \( \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 2 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred after death. Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen G. Shaw, M.D. Anne Arundel Medical Center, Annapolis, MD 21401 32. Raistrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 1 2004 Registrar

			1- For State of Maryland / Dep	ertificate of Death	Mental Hygie	
i.	¢(()	-	Decedent's Name (First, Middle, Last)		2. Date of Death  Month	Day Year 3. Time of Death
	Physici /Medic		Nunziato Lusi			2 2004 1213 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death
1			5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Brankyune Il Under 1 Year   Il Under 24 Hrs		
	Funeral Director		579-68-8224 1X M 2□ F 62 Yrs.	Months Days Hours Min		9. Birthplace (State or Foreign Country) 1941 Italv
	D		Usual Residence of Decedent		march 10,	1941 Icaly
	arylan show	_	10a. State 10b. County 10c. City, Town or I	cocation		10d. Inside City Limits 1 ☐ Yes ※☐ No
	Ne Mi	Director	Maryland Prince George's Bran	dywine 10f. Zip Code		
	with t			·	109.	Citizen of What Country?
	ms 23	Funeral	16020 McKendree Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	20613  Was Decedent of Hispanic Origin? (Salf Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	USA 14. Race - American Indian,
0	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or Items 23e or 28e-f show event, The Medical Examine must be notified at		1 Never Married 2 Married Armed Forces? 1 Yes, 2 M No	If Yes, specify Cuban, Mexican, Puer  1 ☐ Yes 2 ☒ No Specify:	to Rican, etc.)	Black, White, etc.
	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Specify: White
ה	"natu	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	orking 16b	. Kind of Business/Industry
7	withir ene.	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	inter	1	JS Government
<u> </u>	Hygi other	Be C	17. Father's Name (First, Middle, Last)		me (First, Middle, Maid	
ומוומ	should be nd Mental marked	To B	Vittorio Lusi	Giovin	a Pasque	
Mary	s 1 and 2 should if Health and Men item 27 is marke other traumatic			ling Address (Street and Number or R		
, ×	and eaith m 27 her tr			8 Ellenwood Drive		
2	iges 1 and of Hear		1 LABURAL 2 Cremation 3 Hemoval from State	ematory or other place)		. Location - City or Town, State
altimor	t Partmer			Memorial Gdns 1-2 22. Name and Address of Facility	/-04 Wa	aldorf, MD
0	Depa Impo		H RAIN H	untt Funeral Home	4£ MD 00	2004
5			23a. Part1. Enter the disease, or complications that caused the death. Do not en	. 0. Box 156, Wallstret the mode of dying, such as cardia		Approximate
	Physician		shock, or heart laiture. List only one cause on each line.  Immediate Cause (Final disease or condition  Gunchot Wol	and to they	+	Interval Between Onset and Death
	/Medical	8	resulting in death)  Due to (or as a consequence of):	, , , , , , , , , , , , , , , , , , , ,	•	
	Examiner		Sequentially list conditions, b.			
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury			
	xecut and al-trar	xan	that initiated events resulting in death) Last C. Due to (or as a consequence ol):			
00/0	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	C <sub>d</sub>			
Ŏ	tificat ng phy as th					
Š	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
,	he death certific: the attending pl shed for use as t	Physician/M		Other (specify)		Month Day Year
Ĭ.	hat th od by detact		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tobacc	to use contribute to the cause of death?
corus,	w requires that the de been signed by the should be detached	d by		and only and one of the second	1 ☐ Yes	2.2No 3 Probably 4 □Unknown
Š	w req	Completed			24a. Wasan	24b. Were autopsy findings available
ב	rsician: The law s certificate has t lirector, page 2 s	mo			autopsy performed	prior to completion of cause of death?
0		0	25. Was case referred to medical	26. Place of De	1 ☐ Yes 2 ☐ 1 ath (Check only one)	No 1 Yes 2 No
> 5	Physician: this certific al director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing H	lome 5 Residence	6 □Other (Specify)
	ing Pi	10.0	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  1 Natural 5 Pending	Work?	28d. Describe how in	jury occurred to chest,
	tendi Jeath tor: A	catl	2 Accident investigation Andrew 4/2011			noticited to chest,
ZIVIS	or At after of Dirac in by	Certification:	determined   286. Place of Injury - At nome, farm, s	treet, factory, office	City or Town, St	and Number or Rural Route Number, ate) I 6000 Keck encence An dy wike with land
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the cause	(s) and manner as stated.
	n 24 t n 24 t he Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	urred at the time, date a	and place, and due to the cause(s)
	To t	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
_			I follow by Soll er So	A0057927	JA	weey 27 2004
R	RIN		30. Name and address of person who completed cause of death (Item 23a) (Type South of the South	Print) Drive	(62.21.	May Had
-	Sta	nte.	31. Date liled (Month, Day, Year) 32. Registrar's Signature	1	my,	Joney 1
	Registr		JAN 2 3 2004 Lileur 15	books		

			1 - For State	State of Maryla		tment of I			iene2004	03124
	Physici /Medic		1. Decedent's Name (First, Middle, Las	LAYTE	N			2. Date of Dear Month	Day Z Year	3. Time of Death 4 1812 M
	Examin Funeral Director	er	4a. Escility Name (If not institution, give  5. Social Security Number  6. Se 219-07-6760	ursing Ho	ME (s. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day 11-21-	4c. County of Dea Will Corr (Year) 9. Bir Corr 1920	thplace (State or Foreign buntry) Md.
	ō	tor	Usual Residence of Decedent  10a. State 10b. County  Md. Wicomic		City, Town or Loca					10d. Inside City Limits 1 ☐ Yes 2√ No
	ath with the 23a or 28a-	Funeral Director	10e. Street and Number 25957 Delmar Rd.			10f. Zip Code 2183			USA	
920	within 72 hours after death with the Maryland ene. than "naturat", or itams 23e or 28e-f show he Medical Exempler must be notified at	by Fune	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		as Decedent of Yes, specify Cub ☐ Yes	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	Pican, etc.)	Black, White	
21215-0036		Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12) 1 1		(Give ki	int's Usual Occu ind of work done O NOT use retire & Oper	during most of work ad)	king	16b. Kind of Business Restaura	
Maryland 2	should be filed ind Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Harold McKinley F		10h Mailine	Address /Strag	Virgini	a Bailey	Maiden Surname)  Bennett r, City or Town, State,	Zin Code)
	es 1 and 2 sho of Health end f item 27 Is m r other traum		19a. Informant's Name/Relationship (7  Joseph Layton, Hu  20a. Method of Disposition  1 X Burial 2 Cremation 3 C	sband 20k	25957 D. Place of Disposi cemetery, crema	Delmar	Rd. Mard	ela Spri	ngs, Md. 2 20c. Location - City or	1837 Town, State
Baltimore,	permit. Peges 1 and 3 Department of Health Importent: If item 27 any injury or other tr ance.		* 4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	) M	22.	Name and Addr	aamal Home	Tno	Mardela Sp	rings, Md.
	Physician		23a. Part1. Enter the disa se, or som shock, or heart failur. List of the disasse or condition	lications that caused the di no cause on each line.	eath. Do not enter	The mode of dy	ing, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. LIVER  Due to (or as a cons  DEEP	2 CA	NCER US T	1+ROM B	3051S		
68760,	cate be execul physicien and the burial-trar	cai	resulting in death) Last	d. AS	sequence of):					
P.O. Box 6	thet the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 1	Ectopic pregnan Other (specify)	су		23d. Date of de Month	livery Day Year
	w requires thet the been signed by th should be detache	ted by Pt	Part II. Other significant conditions of	entributing to death but not	resulting in the und	derlying cause g	iven in Part I.		bacco use contribute to	o the cause of death? robably 4 Dunknown
Vital Records,	The law ate has b page 2 st	e Comple	25. Was case referred to medical				Of Blood of Doo	24a. Was a autops perfor 1 Yes	sy prior to death? 2 No 1 Yes	utopsy findings available completion of cause of
n of Vit	Phy this ald	To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatient 28b. Time of Injury	28c. Inj	ther: 4 Nursing Hours at ork?	ome 5 Resid	ence 6 Other (Spe ow injury occurred	ocify)
Division of	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		at home, farm, stre		]Yes 2 □No	28f. Location (S City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical (	(Check only 2 Medical Exan	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death nination and/or invi	estigation, in my	time, date and place opinion, death occu	rred at the time, d	ause(s) and manner a date and place, and du	e to the cause(s)
	or with	2	29b. Signature and title of certifier	completed cause of death (  ICE Hufford  32. Registrar's Si	Itom 22a) (Tuno E	D 5	7952		1/13/	2004
	St	ate	30. Name and address of person who Babwal Das 31. Date filed (Month, Day, Year)	/	gnature A	504B.	Salisba	nry,	MD 2/8	104.
	Regist	rar	JAN 142	1004 Dener		you	ns			

Physician /Medical Examiner  1. Decedent's Name (First, Middle, Last)  JOHN MILLER LEWIS  4a. Fecility Name (If not institution, give street and number)  A. Fecility Name (If not institution)  A. Fecility Name (If	8. Date of Birth (Month, Day, Ye 04-26-192	25 SMITH	ce (State or Foreign y) ISLAND MI d. Inside City Limits 1 □ Yes 2√ No
Funeral Director  Funeral Director  4a. Fecility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Saulsburg  Saulsburg  Saulsburg  Funeral Director  5. Social Security Number  220-16-9749  Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  WILLARDS  10e. Street and Number  7949 GREEN LEWIS ROAD  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent Ever in U.S.  14. Security Number of Death  4b. City, Town, or Location of Death  Ab. City, Town, or Location of Death  4b. City, Town, or Location of Death  Ab. City Town, or Location of Death  Ab. City Town, or Location of Death  Ab. City Town, or Location of Death  Ab. City Town, or Location of Death  Ab. City Town, or Location of Death  Ab. City Town, or Location of Death  Ab. City Town, or Location of Death  Ab. City Town, or Location of Death  Ab. City Town or Location of Death  Ab. City Town, or	8. Date of Birth (Month, Day, Ye 04-26-192	ear) 9. Birthpla Country 25 SMITH	ce (State or Foreign y) ISLAND MI d. Inside City Limits 1 \( \text{Yes} \) 2\( \text{No} \)
220-16-9749  Usual Residence of Decedent  10a. State  10b. County  MD  WICOMICO  WILLARDS  10c. City, Town or Location  WID WICOMICO  WILLARDS  10c. Street and Number  7949 GREEN LEWIS ROAD  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Special Status) (Symmet Forces)	04-26-192	25 SMITH  10x  Citizen of What Country	ISLAND MI  d. Inside City Limits  1 □ Yes 2√ No
10a. State 10b. County 10c. City, Town or Location  MD WICOMICO WILLARDS  10a. Street and Number 10b. Zip Code  7949 GREEN LEWIS ROAD 21874  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Springer) (Street Advised Billiage)		. Citizen of What Countr	1 ☐ Yes 2√ No
			v?
	Rican, etc.)	14. Race - American	
To be the string of the string		Black, White, et	
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  HARNESSMAN	ang	b. Kind of Business/Indu ARNESSMAN AS	
Elementary/Secondary (0-12) College (1-4or 5+)  HARNESSMAN  18. Mother's Name  CARRIE HI  JOSEPH LEWIS  19a. Informant's Name/Relationship (Type, Print)  DEBRIE LEUIS - SPOUSE  70.40 CREEN LEUIS - SPOUSE	e (First, Middle, Maid JDSON	iden Sumame)	
DEBBIE LEWIS - SPOUSE  7949 GREEN LEWIS RD. WI  20a. Method of Disposition  1 M Burial 2 Cremation 3 Removal from State	LLARDS ,	ity or Town, State, Zip C  MARYLAND 2.1  c. Location - City or Town  TTSVILLE - MA	1874 n, State
21. Signature of Funeral Service Licer lee  22. Name and Address of Facility BOU  705 EAST MAIN STREE  23a. Part]. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	JNDS FUNER ET, SALISB	RAL HOME, IN BURY,MARYLAN	NC. ND 21804
Physician /Medical Examiner  Physician /Medical Examiner  Sequentially list conditions, and beautiful to immediate ausse. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		Ir	pproximate nateval Between Interval Between Inset and Death
Second   S		23d. Date of delivery Month Da	ay Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		2 No 3 Probab	cause of death?
We we will the state of the sta	24a. Was an autopsy performed 1 Yes 2 2		y findings available letion of cause of
25. Was case referred to medical examiner?  1		e 6 □Other (Specify) niury occurred	
5 g G G G Homicide building, etc. (Specity)	28f. Location (Street City or Town, St	t and Number or Rural R late)	oute Number,
29a. Certifier  Check only one)  29a. Certifier  (Check only one)  29a. Ce	ed at the time, date a	and place, and due to th	e cause(s)
29b. Signature and title of certifier  29c. License number  4005 > 410  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Date signed (Month, Day	y, Year)
30. Name and address of person who compreted cause of death (Item 23a) (Type, Print)  State Registrar  31. Date filed (Month, Day, Year)  AN 1 3 2004  Separate Begistrar	MD 21	80/	

			State		artment of Health and M	•	•	
			1 - State Registrar		rtificate of Death	_	. No. 2004	03126
r	Physici	ian	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Ruth Goldie Lancaste  4e. Facility Name (If not institution, give street and r		4b. City, Town, or Location of Death	JANUARY	4c. County of Death	4:26 P M
	Examir	ıer	Doctors Community Hos		Lanham		Prince Geo	rae's
	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Y		plece (State or Foreign ntry)
45	Director	ļ	214-16-7964  Usual Residence of Decedent	95 Yrs.	Months Bays Hours Min.	4/4/08		verly,Md.
28	yland now		10a. State 10b. County	10c. City, Town or Lo	ocation		1	10d. Inside City Limits
	a-fst	ctor	Md. Prince George'	S	College Park			1X Yes 2 No
	death with the Maryland rms 23a or 28a-f show r must be notified at	Director	10e. Street and Number		10f. Zip Code	10g	g. Citizen of What Cour	ntry?
	s 23a	in a	5022 Lakeland Road	cedent Ever in U.S. 13.	20740	- it. Var an Na	U.S.A.	an tadia
0030	be filed within 72 hours after death with the Marylar Hydione.  Ad othar than "natural", or liems 23a or 28a-f show avant, the Medical Examination must be notified at	by Funerai	Armed	Forces? 2 1 No Bive	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	14. Race - Americ Black, White, Specify: B1	
5	be filed within 72 hours after ital Hygiene. d othar than "natural", or Ite avant, the Medical Examina	Completed	15. Decedent's Education (Specify only highest grade completed	f) (Give	dent's Usual Occupation b kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business/In	dustry
7 7	with iene. r than	dwo	Elementary/Secondary (0-12) College 2 yrs.	(1-4or 5+)	ecretary	t	J.S. Govern	ment
2	e filed of har vant,	BeC	17. Father's Name (First, Middle, Last)			(First, Middle, Ma		
vand	should be ind Mental s marked o umatic ava	ToE	Johnny Johnson		Sarah	Butler		
Mar	and ls m		19a. Informant's Name/Relationship (Type, Print)  Roy S. Few/ Nephew		ng Address (Street and Number or Rura 1 Plaid Dr., Laure		City or Town, State, Zip 20707	(Code)
กั	s 1 and of Health item 27 other tr		20a. Method of Disposition	20b. Place of Dispo	osition (Name of		c. Location - City or To	own, State
	permit. Pages Department of Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	n State	Matiny or other place) Nat'l. Mem. Park	1/16/04 T	aurel Md.	
	permit. Departminimporta Importa any inju		21. Signature of Funeral Service Licensee	2	2. Name and Address of Facility			
0	80119		any w.	Josale 4	H.S.Washington & 925 Burroughs Ave.	,N.E.,Was	h.,D.C. 20	019
	Physician /Medical		23a. Part1. Enter the disease, o complications that shock, or heart failure. List only one cause or immediate Cause (Final disease or condition resulting in death)  Due I	caused the death. Do not en- each line.	er the mode of dying, such as cardiac of			Approximate Interval Between Onset and Death
\$	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	o (or as a consequence of):				
,007	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cai	that initiated events resulting in death) Last C. Due to	o (or as a consequence of):				
00 X	entifica ding pl	/Med	IF FEMALE:					
O. DOX	the death c the attend ched for us	Physician/Med	in the past 12 months?	gnant at time of death 5	Ectopic pregnancy Other (specify)	<del></del>	23d. Date of delive Month	ory Day Year
Ļ	s that ned by deta	by Ph	Part II. Other significant conditions contributing to	death but not resulting in the u	ndarlying cause given in Part I.	23e. Did tobac	cco use contribute to th	ne cause of death?
cords,	en sig	ed b	Weight his, a	& Crewsed	1000 P	1 🗆 Yes	2 ☐ No 3 ☐ Prob	abiy 4 Minknown
200	The law re the has be page 2 sho	Completed	fluid interlet			24a. Was an autopsy performe	d2 prior to cor death?	psy findings available mpletion of cause of
	artifica ctor, (	Bec	25. Was case referred to medical examiner?	-	26. Place of Death			
5	hysic this co	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐	Inpatient 2 ER/Outpatier			e 6 □Other (Specify	0
CIVISION	eath. or: After the funera	Certification:	1 Natural 5 Pending (Mo	e of Injury 28b. Time o nth, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
	or the hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		4 Homicide determined 299. Flat buil	ce of Injury - At home, farm, str ding, etc. (Specify)		City or Town, S		
	e Hosp 124 hou e Fune letely fi	edical	(Check only 2 Medical Examiner: On the	ne best of my knowledge, deati basis of examination and/or in nner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurred.	and due to the caus ed at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	withir To th	Me	29b. Signature and title of certifler	MN	29c. License number m b 051398		Date signed (Month, I	Day, Year)
			30. Name and address of person who completed car 8909 Old Branch Av			20739	5	
i	Sta		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	nton, mayland			

		1 - For State Registrar	State of Marylan		artment of F		Mental Hygier	2001	0312	
Physici /Medio Examin	al	Decedent's Name (First, Middle, Las.     Mary Klear     4e. Facility Name (If not institution, give	Miles		4b. City, Town, o	r Location of Death	January 2	Day Year 23, 2004	3. Time of Death 2:25 p.n	
Funeral Director		44755 Woodlake ( 5. Social Security Number 6. Se 216-22-3465 Usual Residence of Decedent				alifornia	8. Date of Birth (Month, Day, Yea	St. Ma	ry s	
within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-1 show fra Modical Exerciper mast be rollified at	Director	10a. State 10b. County  Maryland St. Ma  10e. Street and Number	nry's	ly, Town or Lo	Califo	ornia	10g. C	10d. Inside City Limit: 1 ☐ Yes 2  No. 10g. Citizen of What Country?		
be filed within 72 hours after death with the Marylan del thygliene. del thygliene interests or 28a-1 show event, I're Macilcal Execiliter interests the rediffed at	by Funeral	44755 Woodlake ( 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Court, Apt. #7  12. Was Decedent Ever in U. Armed Forces?  1 \( \text{Yes} \) 2 \( \text{D} \) No if Yes. Give Year or Dates:	.S. 13. V		0619 lispanic Origin? (Sp an, Mexican, Puerto Specify:		nited Sta 14. Race - Amer Black, White Specify: Whi	ican Indian, , etc.	
within 72 ho	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give		during most of work 1)	ing 16b.	Kind of Business/In	ndustry	
be filed ital Hygi of other evant, I	To Be Co	12 17. Father's Name (First, Middle, Last) John Gilbert Kle	ar	Clerk	of Circu		S e (First, Middle, Maide Paul Abel		ernment	
1 and 2 sh Health and am 27 is m thar traum		19a. Informant's Name/Relationship (7) Rose Theresa Cleme 20a. Method of Disposition	nts / Sister	23077	Newtowne	and Number or Run	al Route Number, City ad, Leonar	or Town, State, Zi	aryland 20	
permit. Pages Department of Important: If it any injury or o once.		1 Burial 2 Cremation 3 F '4 Donation 5 Other (Specify)  21. Signature Fuperal Section 5  Edward N. Brinsfi	Br	insfie	. Name and Addres	s Cr. 1-29	-2004 Chansfield Fu	rlotte Ha	all, MD ne, P.A.	
Physician /Medical Examiner		23a. Pert1. Enter the disease, or compleshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ications that caused the death	n. Do not ente	er the mode of dying	g, such as cardiac	d, Leonard or respiratory arrest,		Approximate Interval Between Onset and Death	
ysician and	Ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t							
e attending p od for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnat 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 1	Ectopic pregnancy Other (specify)	7		23d. Date of deliver	əry Day Year	
engine pe o	by	Part II. Other significant conditions cor	stributing to death but not resu	ulting in the un	derlying cause give	on in Part I.		use contribute to the	ne cause of death?	
ate has b	Completed						24a. Was an autopsy performed?	prior to co	psy findings availab mpletion of cause of	
After this funeral dir	ıtlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 Vo  27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	ospital: 1	ER/Outpatient 28b. Time of Injury	28c. Injury Work			6  ☐ Other (Specify	y)	
within 24 hours after death.  To the Funaral Diractor: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	···	et, factory, office		28f. Location (Street a. City or Town, Stat	θ)		
within 24 hours after To the Funaral Discompletely filled in	Medical	29a. Certifier (Check only one)  1 Certifying Phys 1 Medical Examinates 29b. Signature and title of certifier	ician: To the best of my know ter: On the basis of examinati and manner stated.	wledge, death ion and/or inve	occurred at the timestigation, in my op	inion, death occurre	ed at the time, date an	d place, and due to	the cause(s)	
Ø R		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, P	Dog 5	5 1985	1/	38 Of	Say (1 dai)	
Stat Registra		SALA L. I-KRTON N 31. Date filed (Month, Day, Year)	1D, OPIS Z 32. Registrar's Signatu	5500	Point la	okeni Rel	Leonard	town, M	D 2065	

		1 - For Stete Registrar	State of Ma	aryland / Dep		ealth and M	lental Hygi	•		
Physic /Medi		Decedent's Name (First, Middle, Las     MARY ELIZABETH M					2. Date of Death Month JANUARY	Day Year 22 200	3. Time of Death 34 8:20AM	
Exami		4a. Facility Name (If not institution, give			4b. City, Town, or I			4c. County of De		
		TALBOT HOSPICE I  5. Social Security Number 6. Se		e (In yrs. last birthday	-	ISTON If Under 24 Hrs.	C. Data of Cinh	TALI		
Funeral Director			_ M 2√ F	85 Yrs.	Months Days	Hours Min.	8. Date of Birth JUNE 8 1	918 WASH	irthplace (State or Foreig Country) HINGTON D.C	
ylanc how		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
ours after death with the Maryland ral, or Hems 23a or 28e-f show Examiner must be polified at	Director	MD TALBO	-	EASTON	10f. Zip Code		100	XXYes 2 ☐ N Dg. Citizen of What Country?		
h with		700 PORT ST., SUI	ጥድ 117		21	601		US	•	
ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban		city Yes or No-	14. Race - Am	erican Indian,	
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be filed within 72 ho tat Hygiene. d other than "natur event, the Modical	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	(Give	edent's Usual Occupat B kind of work done du DO NOT use retired)	ion ring most of workin	ng 16	b. Kind of Busines	s/Industry	
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s 1 and 2 should by f Health and Menta item 27 Is marked other treumatic ex	2	CONRAD MARENE CHA					T MCLAUG			
d 2 sho th and 7 Is m treum		19a. Informant's Name/Relationship (7 JOSEPH H. MANNING	ype, Print)		ing Address (Street an					
1 and 2 Health Iem 27		20a. Method of Disposition		20b. Place of Dispo	BRIDGE RD			CE, MASS		
Pages nent of int: If it		1 Burial 2 Cremation 3 :	Removal from State	cemetery, crea	matory or other place)			,		
permit. Pages 1 Department of H Importent: If ite any injury or otl once.	1	*4 □Donation 5 □Other (Specify  21. Signature of Funeral Service License			E CREMATION  2. Name and Address		23-2004	STEVENSVI	LLE, MD	
Department of the partment of				FE	LLOWS. HET	FENBETN	& NEWNAM	FUNERAL.	HOME PA	
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. PA	the death. Do not ente.  NCRUAT  consequence of):				<del>D 21601</del>	Approximate Interval Between Onset and Death	
be executed ician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	consequence of):						
certificate nding phys		d								
the death ce y the attendir sched for use	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. if yes, outcome of 1□Live birth 2 4□Pregnant at 1 9□Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year	
w requires that the deben signed by the should be detached	by P	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause given	in Part I.			o the cause of death?	
The lar ate has page 2	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of	
ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?			2	6. Place of Death				
Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatien			e 5 🗆 Residenc	e 6 XOther (Spe	cify) HOSPICE	
ig te	Certification:	27. Mann   Death  1	28a. Date of Injury (Month, Day	Yeer) 28b. Time of Injury	Work?	t 21 s 2 🗆 No	8d. Describe how i	injury occurred		
itel or Att rs after d el Direct	Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, str (Specify)	eet, factory, office	21	Bf. Location (Stree City or Town, S	t and Number or Ri tate)	ural Route Number,	
To the Hospitel or Attendir within 24 hours atter death. To the Funerel Director: Al completely filled in by the fun	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exami	sicien: To the best of ner: On the basis of and manner stat	f my knowledge, death examination and/or inv ed.	n occurred at the time, vestigation, in my opin	date and place, ar	nd due to the caus d at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)	
To t With To t	Σ	29b. Signature and title of certifier	25/10	m m	29c. License n	umber 66	29d.	Date signed (Mont	h, Day, Year)	
		30. Name and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of the seen address of th			Print) DLEWILD AV	TACTION	MD 21601			
Sta Begistr		31. Date filed (MJANPa2 73 72004		's Signature	M .	a reporting	TID 21001			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend Item//9perFHG8282/26/04 EW Certificate of Death Reg. No. 🕻 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 06 2004 10:28 PM Day Yeer **Physician** Matthews Donovan Januaru /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAROLINE DENTON BT404 & THAWLEY RD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 01 20 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Min. Months Hours 14 M 2 ☐ F 217 13 2348 16 1987 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r then "netural", or Items 23a or 28e-f show the Medical Examiner must be notified at DENTON CAROLINE 1 ☐ Yes 2 PNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 IHAWLEY RD JSTA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ■ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 3 No Specify: Specify Black \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens. Importent: If item 27 is marked other then \*ne any injury or other treumatic event, I'm Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Student Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Merrick J. Beck Margaret Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Matthews (mother) 22700 Thawley Road Denton, Md 21627 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 01 14 2004 Denton Md. Spring Grove 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral S Dashiell Funeral Service 319 East Dover Street Easton, Mo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FRACTURE Physician FOUTE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner -transit death certificate be executed and Due to (or as a consequence of): the attending physician a hed for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. I ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MASSIVE THORACIC TRAUMA 23e. Did tobacco use contribute to the cause of death? Records, Completed by should be 2 No 3 ☐ Probably 4 ☐ Unknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No N s certificate has t lirector, page 2 s autopsy performed? 2 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Chher (Specify) SENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Medical Certification; To this within 24 hours after death.

To the Funerel Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 01-06-2004 10:28 Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 No HROWN OUT OF AUTOMOBILE 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide RT 404&THAWLEY DENION MD 21629 To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number m 23a) (Type, Print) POB#690, D ENTON MD 21629

State Registrar JAN 2004 Year)

32. Registrar's Agnature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0051 TANUARY 17 2004 GEORGE JAY MARSH, JR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner TALBOT EASTON HOSPITAL MEMORIAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | MAR 24 1923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral X** M 2 □ F WASHINGTON 80 Yrs. Director 534-18-8515 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other then "natural", or items 23s or 28e-f ebor traumatic event, the Madical Experience must be notified at 1 ☐ Yes 2X No Director TALBOT EASTON MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21601 USA 10865 GROSS COATE RD Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 Never Married 2 Married ∑Yes 2 No 21215-0036 4 by ⊦ 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: WHITE 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) PESTICIDE Pages 1 and 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) REGULATION 12 MANAGER 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Heelth and Mental LORETTA GRONO GEORGE JAY MARSH, SR 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Heelth at Important: If itam 27 is any injury or other trau once. 10865 GROSS COATE RD., EASTON, MD 21601 JUDITH MARSH/DAUGHTER more, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 1-18-2004 STEVENSVILLE, MD Balti 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOW, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 Llosoph M. Ostrowski C.F.SF 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Sepsis **Physician** Hours resulting in death) /Medical Due to (or as a consequence of): **Examiner** Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed Hypotension and Due to (or as a consequence of): burial-t cotheter Infection physician Dialysis Physician/Medical as the the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed bluods carotid Disease 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed HO Tronsient Ischemic 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has Vein Thrombosis 2200 HO Deep certificate 1 🗆 Yes Division of Vital ector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatrent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No B 2 this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification; 5 Pending investigation Attending Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by after 4 Homicide Hospitel or within 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0057067 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAMIAN SOOKLAL, 607 DUTCHMANS LANE, EASTON, MD 21601 31. Date filed (Wonth, Day, Year) State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

SEORGE

)			1 - For State Item #18,	State of Maryland / QACHD,01/21/04,kk		artment of F tificate of		d Mental Hy	giene Reg. No.	71111h	03131
	<b>D.</b>	Н	1. Decedent's Name (First, Middle, Last	)				2. Date of De Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Charles Thomas					JANUAR		,2004	12:20P. M
	Examin		4a. Fecility Name (If not institution, give			4b. City, Town, o		eath		County of Deeth	
			129 QUAIL RUN DRIV 5. Social Security Number 6. Se		birthday)	CENTREV  If Under 1 Year			rth	EEN ANNE	plece (State or Foreign intry)
	Funeral Director			XM 2□F 82	Yrs.	Months Days	Hours V	Feb. 4	ay, Year)		ryland
			Usuel Residence of Decedent					11 60.4	<b>p</b> 1 2 2	Ma	10d. Inside City Limits
	ith the Marylan or 28a-f ahow e notified at	2	10a. State 10b. County  Maryland Queen	Annolo Cen		rille					1. Yes 2 No
	the M	Directo	10e. Street and Number	Anne s con		10f. Zip Code			10g Citi	zen of What Cou	
	death with the Maryland ms 23a or 28a-f ahow f must be notified at		129 Quail Run D	rive			1617		-	S.A.	,
	ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent of I	Hispanic Origin?	(Specify Yes or N		14. Race - Amer	
020	or Ite	Ď	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No WWII If Yes, Give Year or Dates: 1942		f Yes, specify Cub 1 ☐ Yes 2 🙀 No		reno rican, etc.)		Black, White Specify: W	hite
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	alth ar		Lois M. Muntair		129	Ouail 1	RunDr.	Centre	zill	o . Md . 2	1617
ē,	of Health of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place	e of Dispo	sition (Name of natory or other pla		/20/04		cation - City or T	
аппо	Page nent o ant: # ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	nemoval mum state		erans (	0 1		Hur	lock.M	aryland
Dall	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lie 11	Wellen lies:	22 F	Name and Addre	Helfer				= 15
3			23a. Pert1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. I	Do not ente	er the mode of dy	ng, such as card	diac or respiratory	arrest,	EVILLE	Approximate Interval Between Onset and Death
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ds, r	w requires that the been signed by th should be detache	by	Part II. Dther significant conditions of	intributing to death but not resulting	ng in the u	nderlying cause gr	ven in Part I.		tobacco u Yes 2 [		the cause of death?
Hec	e law has b	Completed						24a. Wa auto perf 1 Yes		24b. Were aut prior to co death?	opsy findings available ompletion of cause of
	icien: Th certificate rector, pag	ø	25. Was case referred to medical				26. Place of	Death (Check only			-7
>	Physicien: this certific al director.	To B	examiner? 1 XYes 2 No		/Outpatien	it 3□ DOA Ot	her: 4 Nursin	g Home 5 ☐ Res	idence (	Other (Spec	(fy) SCENE
0	ding Ph J. After th funeral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	Wo	ork?	28d. Describe	how injur	y occurred	exercit 1
DIVISION		Certification:	2 Accident investigation 3 Suicide 6 Could not be	13 -		P	Yes 2 No	204 Landian	(Stroot or	Little La	Hufure
₹	or At after c Direc in by	artifi	4 Homicide determined	building, etc. (Specify)	e, rarm, str	eet, factory, office		City or To	wn, State	129 94	al Route Number,
_	the Hospital or Attan in 24 hours after deat the Funerel Director: npletely filled in by the	S C	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my knowle	dge, death	n occurred at the t	me, date and p	ace, and due to the	cause(s)	and manner as	stated.
	e Ho: 24 h e Fur letely	edicai	(Check only 2 X Medical Examone)	iner: On the basis of examination and manner stated.	and/or in	vestigation, in my	opinion, death o	ccurred at the time	, date and	place, and due	to the cause(s)
	To the Hospital or within 24 hours after To the Funerel Director Completely filled in b	Me	29b. Signature and title of certifier	1.		29c. Licen	se number		29d. Dat	e signed (Month	, Day, Year)
			Theodor U.	lif um		0.C	.M.E.		JANUA	ARY 16,2	2004
			30. Name and address of person who	1				\.			
			71 KEODERE MIK			111 Penn	Street	, Baltimo	re, l	Maryland	21201
	Sta Registr		31. Date filed (Month) Par (Year)	32. Régistrar's Signature	7. 6	barle					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MalleT JANUARY 17, ar querite 2004 12:50 AM /Medical 4a Facility Name-(f not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH ARUNDEL HOSPITAL ANNE ARUNDEL GLEN BURNIE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🕱 F Yrs. 51 215-64-3757 19, 1952 MARYLAND Director Usual Residence of Decedent filed within 72 hours efter death with the Marylenc 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Funeral Director ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 FERNDALE AVENUE 21061 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: WHITE ۾ 3 ☐ Widowed 4 X Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CIVIL SERVICE 12 4 RATINGS SPECIALIST th end Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 end 2 should be i Depertment of Health end Mental important: If item 27 ia marked of GEORGE MALLET JUNE DILLEHAY 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GEORGE MALLET/FATHER 410 BENTON RD., STEVENSVILLE, MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State JAN. 20 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY STEVENSVILLE, MD 2004 21. Signature of Funetal Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Physician Small Cell Luna /Medical Immediate Cause (Final 20 months disease or condition resulting in death) Examiner Examine 00001 ician and burial-transit or Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient ≥ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural within 24 hours efter death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier (Check only one) TX certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 death occurred at the time, date and place, and due to the cause(s) and menner steted. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Ifem 23e) (Type, Print) quahart Road Glen Burnie MD 21061 2004 32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day (141)

			1 - State of Maryland / Department of Healt Certificate of Dea		lygiene 200	4 03133
	Phys	ician	1. Decedent's Name (First, Middle, Last)	2. Date of I Month	Death Day Yea	3. Time of Death
		dical	Dorothy Marie Morton	01	15 04	
	Exam	niner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local	ation of Death	4c. County of De	omico
	- Fund		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year	Inder 24 Hrs. 8. Date of E		Birthplace (State or Foreign Country)
	Funer Direct	_	213-22-7619 1 M 2 F 77 Yrs. Months Days Hot	ours Min. (Month, 01/12	Day, Year) /1927 Ch	ester, PA
C	P >		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
1619	d 21215-0036 filled within 72 hours after death with the Maryland Hygiene, the Hear 23s or 28s-1 show ther than "natural", or Items 23s or 28s-1 show ent, it is Medical Evanther must be notified at	Completed by Funeral Director	Delaware Sussex 15412 Abbotts Pond Ro	oad, MILFORD		1 ☐ Yes 2X No
1	with the or 2	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of What	
22	eath w	eral	15412 Abbotts Pond Road 19963  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispani	ic Origin? (Specify Yes or	United St	ates merican Indian,
3	fter dea	F.	Armed Forces? If Yes, specify Cuban, Me		Black, W	
5	036 ours aft ral', or Evand	þ	3XXVidowed 4 □ Divorced If Yes, Give 1 □ Yes 2XXNo Special Sp	ecify:	Specify:	White
	5-00: 72 hours "natural", dical Ex	etec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)	most of working	16b. Kind of Busine	ss/Industry
7	within ene.	ш	Elementary/Secondary (0-12) College (1-4or 5+)		Cabaal D	d a b m d a b
DoroThe	ind 212 be filed with tal Hygiene. d other than	ပိ	12 Cafeteria Worker	L Mother's Name <i>(First, Mid</i> d	School D	ISTITCT
2	E B E B S	To Be	William Henry Taylor Sac	die Ella (Cl	oud) Taylor	
O			19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and No.	lumber or Rural Route Nur.	nber, City or Town, State	, Zip Code)
-	- m -		Everett T. Morton, Son 412 Valley Wood	Dr., Salisb	ury, MD 2	1804
B			20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	or Town, State
artan	Pages ment of lant: If it		'4 □Donation 5 □Other (Specify) Hollywood Cemetery		4 Harringto	n, DE
S	Baltimol permit. Pages Department of Important: If i	once	21. Signature of Funeral Service Licensee  22. Name and Address of F S. DuPont Hig	Meivin	Funeral Homngton, DE	e, 15522 19952
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc shock, or heart failure. List only one cause on each line.	ch as cardiac or respiratory	/ arrest,	Approximate Interval Between Onset and Death
	Physicia		Immediate Cause (Final disease or condition resulting in death)  a. Respiratory Arv	rest		Oliset and Death
	/Medic Examin		Due to (or as a consequence of):			
	* 4	-i-	if any, leading to immediate cause. Enter Underlying			
	betr	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.			
	760, be executed sician and burial-transit	Exa	resulting in death) Last Due to (or as a lonsequence of):	0		
	760, tte be ex nysician ne burial	cai	· Urinary Tract I	nfection		
	rdiffica ng ph as th		IF FEMALE:			
	of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1   Yes   2		23d. Date of o Month	delivery Day Year
	that the de detached is	Ph.	Part II Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I 23e. Di	id tobacco use contribute	to the cause of death?
	cords, w requires to been signed should be	ted by	Deep Venous Thrombosis,		□Yes 2□No 3□	Probably 4 Dunknown
	Aeco e law r has be pe 2 sh	Completed	Houte Renal Failure,	24a. Wi	topsy prior t	autopsy findings available o completion of cause of
	The I trained to the I	Co	Anemia	1 ☐ Yes	orformed? death s 2 No 1 ☐ Y	es 2□No
	f Vital F sysician: Th us certificate director, pag	Be	examiner?	Place of Death (Check ont		
	Of Phys r this ral dii	٠. ا	Patient 2 Elitoupation 3 Box 4	Nursing Home 5 ☐ Re 28d. Describ	esidence 6 Other (S <sub>i</sub>	pecify)
	ion ( th. After a funer	盲	27. Manner of Death  1 Manner of Death  1 Manner of Death  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  2 □ Accident investigation	2 🗆 No		
	Division of Vital Records, to attending Physician: The law requires tater death.  Director: After this certificate has been signed in by the funeral director, page 2 should be as	ertification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or 1	n (Street and Number or Town, State)	Rural Route Number,
	Division o  To the Hospitat or Attending Pl within 24 hours after death To the Funeral Director: Attent completely filled in by the funeral	edical C	29a. Certifiler  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, da 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	ite and place, and due to the time.	ne cause(s) and manner ne, date and place, and c	as stated. ue to the cause(s)
	To th within To th	Me	29b. Signature and little of certifier 29c. License num		29d. Date signed (Mo	
			May telle HAD Door	60225	January 13	7, 2004
		(	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	60225 1 57. PN/	7.	
		0.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 5T. PM.	NEESS ANNE	-, m5
		State istrar	IAN 1 6 2004			

			1 - For Stete Registrar	State of Ma	iryland / D	epartme <i>Certifica</i>	nt of H te of I	eaith and M Death	Re	g. No.	4 03134
	Physicia	an	1. Decedent's Name (First, Middle, Las		.11				2. Date of Death Month	Day Year	
	/Medic	al	Miriam Elizak		3TT	41.03	T	Landing of Dank	January		
ł	Examin	er	4a. Facility Name (If not institution, give Angelic Arms	street and number)		46. City		Location of Death  VLOWN		4c. County of De Carr	
	E		5. Social Security Number 6. Sec	ex 7. Age	(In yrs. last birth	nday) If Und	er 1 Year	If Under 24 Hrs.	8. Date of Birth		
	Funeral Director			□м 2√ДF	93 Y	rs. Months	Days	Hours Min.	(Month, Day, Oct 1,	1910 Ma	irthplace (State or Foreign Country) ryland
	put 3		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	Maryk f sho	Į		imore	7.			Upperco			1 ☐ Yes 2½ No
	r 28e	Director	10e. Street and Number			10f. Z	ip Code		10	g. Citizen of What C	Country?
	23e c	ralD	15220 Old Hanover	r Road				21155		USA	
	r dea	nue	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	within 72 hours after death with the Maryland ane . than "natural", or items 23e or 28e-f show the Madical Exemplar routs be modified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2⊠N If Yes, Give Year or Dates:	o	1 ☐ Yes		Specify:			white
9	2 hou		15. Decedent's Ed	ucation	16a. (	Decedent's Us	ual Occupa	ation	11	6b. Kind of Busines	s/Industry
212	ithin 7 ie.	Completed	(Specify only highest gra	College (1-4or 5		life. DO NOT	use retired		ng	Automobi	le Company
2	filed w Hygier Sther th	Co	17. Father's Name (First, Middle, Last)			Secr	etary	7 18. Mother's Name	/First Middle M		re company
Maryland 21215-0036	d be f ental b red of	To Be	Amos W. Belt, S.	r.					V. Rawli		
Ž	should be nd Mental nmarked c	ř	19a. Informant's Name/Relationship (7		19b.	Mailing Addres	s (Street a			City or Town, State,	Zip Code)
	and 2 ealth a n 27 ia		William C. Belt	, brother		5407 G1	en Fa	alls Road	, Reister	stown, M	21136
ore	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than: or other traumatic event, the Marical Examination and the coding of the		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of I cemetery	Disposition (Nation ), crematory or	ame of other plac		ate 20	0c. Location - City o	r Town, State
Baltimore,	tment of items: if items or o		`4 ☐ Donation 5 ☐ Other (Specify	) 0	1	UM Cen			./2004	Upperco,	
Ba	permit. Pages 1 and Department of Heall importent: If item 2 any injury or other 20059.		21. Signature of Fuleral Service Licen	See 2400	123			s of Facility h Main St		neral Hon ead, MD 2	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do no	1	-				Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition resulting in death)	a. DIA	tte G	15Ch	·Emi	C CAR	siony	opathu	Onset and Death
	/Medical Examiner		Tosailary in deality	Due to (or as a	consequence of	7):					8.
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of	i):					
	outed od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
Ö,	e exe sian ar urial-t		resulting in death) Last	Due to (or as a	consequence of	·):					
68760	ficate be executed physician and ts the burial-transit	edical	•	d							
Box 6			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy	_				23d. Date of de	elivery
m m	death le atte ed for	Physician/M	in the past 12 months? 1 □ Yes 2 X No	1 ☐ Live birth : 4 ☐ Pregnant at : 9 ☐ Unknown		3 □Ectopic   5 □ Other (s				Month	Day Year
P.O.	at the	Phys	9 Unknown								
Division of Vital Records,	The law requires that the death certif tle has been signed by the attending bage 2 should be detached for use a	Ď	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the underlying	cause give	on in Part I.	1 ☐ Yes	1	to the cause of death?
eco		Completed							24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
<u>=</u>		Col							performe 1 ☐ Yes 2	death?	s 2 No
<u> </u>	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatier	nt 2□ER/Out		Othe	26. Place of Death		. <b>X</b>	ASSISTED
o	Attending Physician: r death. ector: After this certific: by the funeral director,	n: To	1 Yes 2/2 No 27. Manner of Death	28a. Date of Injur	y. 28b. Tir		28c. Injury Work	4   Nursing Hor	ne 5 🗆 Hesiden 28d. Describe how	ce 6 <b>X</b> Other ( <i>Spe</i> injury occurred	ecity) Level
ion	ath. rr: Afte	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation		rear) inj	ury M		r res 2 □ No			
<u>`</u>	of or Attending Patter death.  Director: After the in by the funera	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	ry - At home, farr . <i>(Specify)</i>	n, street, facto	ry, office	2	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
<b>_</b>	spital ours a neral E		29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowledge	death occurre	d at the tim	e. date and place	and due to the cau	se(s) and manner a	s stated
	To the Hospital or Atten within 24 hours after deat VTo the Funeral Director: completely filled in by the	Medical	(Check only one) Medical Exem	iner: On the basis of and manner sta	examination and	or investigation	n, in my op	inion, death occurre	ed at the time, date	e and place, and du	e to the cause(s)
	To 11 within To 11 comp	Ĭ	29b. Signature and title of certifier		0	25	c. License			I. Date signed (Mon	
)	.60)	-	1 trames	12. C	300cm	-	D	31660		01/20/3	7007
(	JE10	-	30. Name and address of person who	5 (-Alu	line à	291	STD	wer a	verve i	westn.	in ster, one
	Sta Registr	- 1	31. Date filed (Month, Day, Year)	32. Redistra	r's Signature	Coard					

			1 - For Stata Registrar	State of	f Marylan		artment of H rtificate of L		nd Mental Hy	giene 200	4 03135
-	Physici /Medio	al	Decedent's Name (First, Middle ROSE     Aa. Facility Name (If not institution)			OOREHE	AD  4b. City, Town, or	Location of	2. Date of De Month JANUAR	Day Yea	1:47 A M
	Examir Funeral Director	ier	CIVISTA MEDIC. 5. Social Security Number 578–28–5919	AL CENTER	7. Age (In yrs.	last birthday) 79 Yrs.	LA PLA  If Under 1 Year  Months Days		4 Hrs. 8. Date of Bin	CHARLE th ly, Year) 9. B	S lirthplace (State or Foreign Country)
	D	tor	Usual Residence of Decedent 10a. State 10b. County MD CHARL	70	10c. City	y, Town or Lo	ecation	-	SEFI.	1924 WA	SHINGTON, DC  10d. Inside City Limits 1 □ Yes 2XNo
	filed within 72 hours after death with the Maryland Hygiene. other then "naturelt, or tems 23s or 28s-f show ent, I'm Medical Esaminer must be notified at	Funeral Director	10e. Street and Number 6080 HANNON DR 11. Marital Status	IVE	dent Ever in U.		10f. Zip Code 20646 Was Decedent of Hi		n? (Specify Yes or No Puerto Rican, etc.)	U. S.	A. nerican Indian,
5-0036	2 hours after aturel', or Ite cal Exarcion	<u>م</u>	1 Never Married 2 Marri XXWidowed 4 Divorced  15. Decedent	If Yes, Giv Year or Da	2V XNo	16a, Dece	1 ☐ Yes 2 🛣 No	Specify:		Specify:	WHITE
2121	a filed within 7; Il Hygiene. other then "ni vent, the Medi	e Completed	(Specify only highes Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, 1	College (1	-4or 5+)		kind of work done d DO NOT use retired, MAKER		of working  s Name (First, Middle,	AT HOME	
Maryland	2 should be and Mental Is marked c	To Be	DOMINC MAGNOLIA  19a. Informant's Name/Relationsh	A nip (Type, Print)				NUNZ]	IATA TROBAS	SSO MAGNOL	, Zip Code)
Baltimore, N	Pages 1 and nent of Health ent: If item 27 ury or other tr		THOMAS MOOREHEAD  20a. Method of Disposition  1X Burial 2 Cremation  4 Donation 5 Other (Signature)	3 Removal from S	Jiaio	lace of Dispo emetery, cren	sition (Name of natory or other place	,)	Date JANUARY	EMOY MARY  20c. Location - City of	
Balti	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service  23a. Part1. Enter the disease, or	158	M006	541 2	Name and Addres	s of Facility Y S AV	AREHART-ECH /E. LA PLAT	HOLS FUNL. [A, MARYLA]	HME., P.A.
	Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. CE	ach line.	ROVA			ACCIDE		interval Between Onset and Death
8/60,	ate be executed hysician and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	or as a consequ						
O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Fetel ant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
ords, P	law requires that the death as been signed by the atter 2 should be detached for u	þ	Part II. Other significant condition	UMON	JIA	ulting in the ur	nderlying cause give	n in Part I.	23e. Did to	obacco use contribute res 2 No 3 □ I	to the cause of death?  Probably 4 □Unknown
Vital Records,	The ate h page	e Completed		BETE		N		26 Place of		prior to rmed? death? 2 No 1 □ Ye	
Division of Vi	Attending Physicien: r death. ector: After this certific: by the funeral director, i	To B	examiner? 1  Yes 2 No  27. Manner of Death 1  Natural 5  Pendin, 2  Accident investig	28a. Date o (Monti ation	npatient 2 If Injury In, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursi	ing Home 5 Resid	dence 6 Other (Sp	ecify)
DIX	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by t	al Certification;	3 Suicide 6 Could r determined 29a. Certifier	p Physician: To the	g, etc. (Specify	viedge, death	eet, factory, office	e, date and p	City or Tox	cause(s) and manner	as stated
)	To the Ho within 24 h To the Fu completely	Medical	(Check only 2 Medical I	An war	sis of examinate er stated.	ion and/or inv	29c. License	number	occurred at the time, o	date and place, and du 29d. Date signed (Mor JAN, 'Z-1	in to the cause(s)  inth, Day, Year)  0 - 2004  1 MD 20622
D	B3_		30. Name and address of person of VTDYASAG1	who completed cause	of death (Item	23a) (Type,	LA, MD.	-CH	O, BOX- ARLOT-	TE HAL	MD 20622
	Sta Registr		31. Date filed (Month, Day, Year)	3 2004	CALLED SIGNAL	K. K	books				

			1 - For State Registrar	S	tate o	of Maryl	land /	Depa <i>Cer</i>	artmen <i>tificat</i> e	t of H e of L	ealth Death	and M	lental H	lygier Reg. I		004	03130
	_		1. Decedent's Name (First, Middl	a, Last)									2. Date of	Death			3. Time of Death
	Physici		Annie		1	Tilley	v	Me	enefe	e			Month Janua		0, 20	Year	11:56A M
	/Medic Examir		4e. Facility Name (If not institution	, give stree				1.4			Location	of Death	Danua.	<u>-</u>	0, 20 4c. County	of Death	
			Southern Mar	yland	Hos	pital			Cl	into	n				Princ	e Co	orge's
	Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last bi	irthday)	If Under Months		If Under	24 Hrs. Min.	8. Date of l	Birth Day Yea	17)	9. Birtho	place (State or Foreign
	Director		579-20-9180	1 □ M	2X1F	78		Yrs.	WOTHING	Days	110013		June :		925		th Carolina
	pu 🛊		Usual Residence of Decedent  10a. State 10b. County			100	City, Tov	vn or Lo	cation								0d. Inside City Limits
	sho	5	Maryland Prince	Coor	7016				Sprin	ac.							1 □ Yes 2 No
	he M	Director	10e. Street and Number	GGOT	96 5			IIIP 3	10f. Zip					10-	Citizen of W	(1	
	hours after death with the Maryland tural', or Items 23a or 28a-f show al Exerciting must be contined at		4705 Dublin D	rive						0746				10g.		U.S.	•
	eath	Funeral	11. Marital Status	12.1	Was Dec	edent Ever	in U.S.	13 V			spanic Or	igin? (Spe	cify Yes or	No-			an Indian,
	fter d	Fun	1 ☐ Never Married 2 ☐ Marri		Armed Fo	orces? 2 🗌 No	1945		f Yes, spec	rify Cubar	n, Mexica	n, Puerto	Rican, etc.)			k, White,	
3	urs al	by	₩idowed 4 Divorced		f Yes, Gr Year or D	ve 1	L946	1	1 ☐ Yes 2	$^2\overline{X}^{No}$	Specify				Specify	:	White
Ę	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show eumatic event, it a Medical Examinar must be untilified at	Completed	15. Deceden				16a	. Deced	lent's Usua	I Occupa	ition	et of work			Kind of Bu		
215-0036	thin 7	ple	(Specify only highe Elementary/Secondary (0-12)			1-4or 5+)		life. L	kind of wor DO NOT us	e retired)	) -	st of worki	ng				ıcation
7	filed within 72 Hygiene. Ither than "nat ont, It e Medic	Com	Elementary/Secondary (0-12)					Bus	Lot	Fore	eman			P.0	G. Co	•	
Maryland	tal Hy d oth	Be (	17. Father's Name (First, Middle,	Last)							18. Moth	er's Name	(First, Midd	lle, Maid	en Sumam	9)	
<u>X</u>	Ment Ment arke	10	Floyd Walter '	[ille	y .						Ros	abel	le		<i>M</i> atson	n	
<u>a</u>	2 she and ls m		19a. Informant's Name/Relations										l Route Nun				,
	5 = 7 = 1		Beverly Ann Mo	Guire	(Da			Wil	low S	Stree	et De		New I				
Baltimore,	m O		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation	3 Remo	val from	State 20	ob. Place o cemete	ny, cren	sition (Nam natory or o	ne of ther place	9) [-	Janua	ry 24,	20c.	Location -	City or To	wn, State
Ē	permit. Pages Department of Importent: If Is eny injury or one		° 4 ☐ Donation 5 ☐ Other (S				ort	Linc	coln (	Cemet	terv	20	_		entwo	d, N	Maryland
ga.	Departition Depart		21. Signature of Funeral Service	Λ		10 7	11		. Name an			ப	ee Fur				
	205 e a		May E. He.			37	7								ad Cl	intor	n, MD20735
١,			23a. Part1. Enter the disease, or shock, or heart failure. List	complication only one ca	ause on e	each line	- 1		Δ.			1					Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_ a		ndStay	elh	Vm C	Ubs	muct	ice Pr	Mone	y Disea	20			Onset and Death
	/Medical Examiner		resulting in death)		Due to	(or as a on	sequence	of):				9					
- A-	LAGITITICI		Sequentially list conditions,	b		The Part of the San San San San San San San San San San	-	- 20									
	ed sit	Examiner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	Due 10	(or as a con	isadnauca	01).									
_	and I-tran	хап	that initiated events resulting in death) Last	С.	Due to	(or as a con	sequence	of):								-	
8760,	cate be executed physician and the burial-transit	ai E				(5. 55 55.		J.,.									
86		dicai		d													
×	death certifi e attending I id for use as	Physiclan/Me	IF FEMALE:	23c. I	fyes, ou	tcome of pre	egnancy								23d. Date	of delive	
Rox	atter for u	clar	23b. Was decedent pregnant in the past 12 months?		1⊡Live t	oirth 2 🗀 l nant at time	Fetal death		Ectopic pro						Mon		Day Year
o.	0 0	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkn				, O.1.101 (apt								
J.	The law requires that the tite has been signed by the bage 2 should be detache		Part II. Other significant condition	ons contribi	uting to d	eath but not	resulting	in the un	nderlying ca	ause give	n in Part I	l.	23e. Did	d tobacc	o use contri	bute to th	e cause of death?
g Q	uires sign	d by											1 (	Yes	2 🗆 No	3 🔲 Prob	ably 4 \understand Unknown
Ö S	w require been si should b	Completed				- 1							24a. Wt	as an	24h W	lere autor	osy findings available
Ĕ	The lav	E G									***		au	topsy rformed?	pi de	rior to cor eath?	npletion of cause of
Vital Records,		e Co	25. Was case referred to medica								00 81		1 🗌 Yəs	2 1	No 1	☐ Yes	2 No
	ysicien: is certific director.	o Be	examiner?	Hosp	ital:	fnpatient :	2 PERVO	utantion	2 00	Othe	P.		(Check only		2 🗆		
Ö	Phys	H .	27. Manner of Death	2	8a. Date	of Injury	28b.	Time of		8c. Injury	at		ne 5 🗆 Re 28d. Describ				")
o	ding Ph th. : After th funeral	flor	1 ☑Natural 5 ☐ Pendir 2 ☐ Accident investi		(Mon	th, Day Yea	r)	Injury	М	Work	? ′es 2. ☐						
Division	l or Attencafter death	Certification:	3 ☐ Suicide 6 ☐ Could		8e. Place	of Injury - /	At home, fa	arm, stre	et, factory	, office		2				r or Rura	Route Number,
S	after Dire	erti	4  Homicide		buildi	ing, etc. (Sp	ecify)						City or T	own, Sta	ite)		
	Hospite 14 hours Funerel tely filled		29a. Certifier 1 Certifyir	g Physicia	n: To the	e best of my	knowledg	e, death	occurred a	at the time	e, date ar	nd place, a	ind due to th	e cause	(s) and mar	ner as st	ated.
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certification completely filled in by the funeral director.	edical	(Check only 2 Medical one)	Examiner:	On the b	asis of exam	nination ar	id/or inv	estigation,	in my op	inion, dea	ith occurre	ed at the time	e, date a	nd place, a	nd due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and the of certifie	•			_		29c.	License	number			29d. [	ate signed	(Month, I	Day, Year)
			> Natura						7	0055	5/20			Jan	hany ?	1 20	04
(	1		30. Name and address of person	who compl	eted caus	se of death (	(Item 23a)	(Type, I	Print)		, /	1	`		-		
1	BIDE		Richard Palmer	MD	1328.	se of death (  Suntur  Sistrar's S	n Are	SE !	inte3	210 h	Jashy.	ngkon	OC 2	0032			
	Sta		31. Date filed (Month, Day, Year)	3 2002	32. F	bistrar's S	ignature		1 4	40							
	Registi	ar	27111 2	- 200	1	THE WAL	, Jo.	1	Post of Stanfor	9							

MCNEFEE

JU	AN R. M		TINEZ 1 - For Unpend Item #23a8 Registrar							Mental Hy			ne.	03138
			Decedent's Name (First, Middle, Last)							2. Date of De	aath			3. Time of Death
	Physici /Medio		Juan R.	ľ.	larti	nez				JAN.	8,	y 2004	Year	7;55 P <sup>M</sup>
}	Examir		4a. Fecility Name (If not institution, give s 821 Priscilla Str					wn, or Loca SBURY	tion of Death		40	. County	of Death	•
4	Funeral Director		5. Social Security Number 6. Sex 467–04–3706  Usual Residence of Decedent	7. Ag		last birthday 8 Yrs.		ear If U	nder 24 Hrs. urs Min.	8. Date of Bir May 20	rth y, year	55	9. Birthpl Coun Texa	ace (State or Foreign try)
	land land		10a. State 10b. County		10c. Ci	ty, Town or L	ocation						10	Od. Inside City Limits
	the Mary 28a-f sh	Director	Maryland Wicomico		Del	mar	10f. Zip Co	nde.		31	10a Cit	izon of 14	hat Coun	Yes 2 □ No
	with with		302 East East Stre	et			21875				US.		nat Coun	tr <b>y</b> r
	death ms 2:	Funeral		12. Was Decedent		J.S. 13.			c Origin? (Sp	pecify Yes or No Rican, etc.)			- America	an Indian,
920	72 hours afler death with the Maryland natural', or Itams 23a or 28a-f show dical Exeminer must be notified at	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Yes 2 <b>XX</b> If Yes, Give Year or Dates:			If Yes, specify						Hisp	enic Danic
Maryland 21215-0036	d within 72 hours after death with the Marylan jene. I than "natural", or itams 23a or 28a-f ahow Ithe Madical Exeminer must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation a <i>completed)</i> College (1-4or 5	5+)	(Give	edent's Usual C s kind of work of DO NOT use r	tone during	most of work	king	16b. K	ind of Bu	siness/Ind	lustry
21	filed wit Hygiene Ather tha	Corr	12			Produ	ice Spec	cialis	st		Fo	od S	ervio	ie
nd	be filed ital Hygie od other event,	Be (	17. Father's Name (First, Middle, Last)				_			ne (First, Middle				
yla	should nd Men marke	To		rtinez					.lda				pez	
Mar	C/ 10 - 0		19a. Informant's Name/Relationship (Ty)							ral Route Numb				ŕ
	s 1 and f Health Item 27 other tr	1	Roxann E. Martinez  20a. Method of Disposition	- wire	20b. I					Delmar, Date			3 218 City or Tov	
nor	Pages nent of nrt: if it iry or o		1 ☐ Burial 2XXCremation 3 ☐ R	emoval from State	4		osition (Name of		1					
Baltimore,			<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Lic.</li></ul>	Α.	Sai		Cremat		-	4/2004				laryland
Ba	permit. Departn Importe any inju		23a. Part 1. Enter the disease, or compli	wey (	esp.		OT PUOM	A HITI	_ Koad	, Salisk	oury	siona , Mai	cylan	sociation d 21804 Approximate
760,	Physician /Medical Examiner and parial-transit	Ical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Chronic A  Due to (or as	1coho a consec	juence of): juence of).	mplicated	l by Hy	potherm	ia				Interval Between Onset and Death
.O. Box 68	that the death certificate be executed ed by the attending physician and detached for use as the burial transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	I death 3	⊒Ectopic pregn ⊒ Other (specif					23d. Date Mon	of deliver	y Day Year
ds, P	w requires that been signed k should be det	by	Part II. Other significant conditions con	tributing to death b	ut not res	ulting in the u	inderlying caus	e given in P	art I.	23e. Did to			oute to the	cause of death?
Vital Records,	<u>a</u> a c₁	Completed								24a. Was autop		pr	iar to com	sy findings available pletion of cause of
<u>ra</u>		CO	25. Was case referred to medical	·				00.0	4	1 Yes	2 🗆 No	1.	ath? Yes 2	2 □ No
		To B	avaminar?	ospital:	nt 2	ER/Outpatier	nt 3 DOA	Othor:		h <i>(Check only o</i> ome 5 ☐ Resid		€ € Othor	(Specify)	AT SCENE
0	문 후 등	ı.	27. Manner of Death	28a. Date of Injur (Month, Day	rv	28b. Time o		Injury at Work?		28d. Describe				AI SCEIVE
io	Attending r death. ector: After by the fune	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(monan, wa)		,ory		1 ☐ Yes 2	2 □ No					
Division of	ial or Attors after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At ho c. (Specif	ome, farm, sti	reet, factory, of	fice		28f. Location (S City or Tox	Street and vn, State	d Number )	or Rural	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of ner: On the basis of and manner sta	examina	wledge, deat tion and/or in	h occurred at the vestigation, in r	ne time, date my opinion,	e and place, death occur	and due to the ored at the time,	cause(s) date and	and man place, ar	ner as sta id due to t	ted. the cause(s)
)	To th withir To th comp	W	29b. Signature and title of certifier  Rawin	108 A	9	-		oense numb O.C.M.			29d. Dat	e signed	(Month, D	(VO4 <sup>ar)</sup>
			30. Name and address of person who con	mpleted cause of de	eath (Iten	n 23a) (Type,	Print)							
			ZABIULLAH +	+4			n Stree	et, Ba	altimo	re, Mar	ylan	1 212	201	
	Sta Registr	-	31. Date filed (Month, Day, Year)  JAN 1 4 200	32. Registra	ar's Signa مصمر	ture &	Spa	K						

		Į,	1 - For State Registrar	State of Maryla		artment of F			iene2004	03139
	Dhysisi		1. Decedent's Name (First, Middle, Last)		N / 2 (2200)		.,	2. Date of Death	Day Year	3. Time of Death
	Physici /Medio		LOLA	MARIE	MATT			JANUARY	14,2004	5:00 p <sup>M</sup>
	Examir	ier	4a. Fecility Name (If not institution, give s 30642 Olde Fruitla			4b. City, Town, o Salish		ath	4c. County of Deet Wicomico	
	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	If Under 24 Hr		. 1	hplece (State or Foreign
Dr.	Director		213-20-3019	M 20XF 75	Yrs.	Months Days	Hours Mir	October 8		ryland
	and W		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Maryl -1 sho	tor	Maryland Wicomico	2	Salisbu	rv				1 ☐ Yes 2 ☐ No
	or 28e	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	ath wi		30642 Olde Fruitla			21804			USA	
	be filed within 72 hours atter death with the Maryland the Hygiene. d other than "natural", or items 23a or 28e-f show event, the Madrell Examinar mast be notified at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No		Was Decedent of H If Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, White	
9	urs af	by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 K No	Specify:		Specify: W	hite
ည် ၁	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup	durina most of w	orking 1	6b. Kind of Business/	Industry
121	within ane. than	idui	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired ewife	a)		Domestic	
א ס	filed w Hygier other tr ent, In	Be Co	17. Father's Name (First, Middle, Last)		IIOus	GMITE	18. Mother's Na	ame (First, Middle, N		
lan I	should be filed nd Mental Hygi marked other imatic event,	To B	George W. Figgs				Gertr	ude Dryde	en	
-	5 m m		19a. Informant's Name/Relationship (Type) Diana C. Hudson/da						City or Town, State, Z	
	s 1 and 2 f Health item 27		20a. Method of Disposition	206	. Place of Dispo	osition (Name of matory or other place	1		Oc. Location - City or	
Ē	Pages nent of ant: If its arry or o		1  Burial 2  Cremation 3  R '4 Donation 5 Other (Specify)	emoval from State		Cemetery	· 1	19/04	Snow Hill,	MD
Baltimore,	permit. Pag Department Importent: any injury o		21. Sunature of Funeral Service License		22	Name and Address Holloway	ss of Facility Funeral	Home Prof	essional <i>P</i>	Association
_	00 E e α		23a. Part1. Enter the disease, or compli	CFSP		OUT PUOM	HITT KO	., Salisbu	iry, MD 218	304 Approximate
	Noveisian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	15/1	Rapala	x (4.	to or respiratory arre	51,	Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a cons	equence of):	17 WCVs	THE CONT			Mmo
Н	Examiner	L	Sequentially list conditions b							
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence or):					
o o	cate be executed obysicien and the burial-transit		that initiated events cresulting in death) Last	Due to (or as a cons	equence of):					
8/60	ate be hysicii the bu	dicai								
٥	attending plor use as i	/Mec	IF FEMALE:	3c. If yes, outcome of preg	inancy				204 Days of 4-11	
ROX	oath for	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fe	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
J.	at the de by the a tached	hysi	9 Unknown	9□ Unknown						
<u>'S</u>	es the	by P	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause give	en in Part I.		acco use contribute to	
o o	w requir been s	eted							_	obably 4 Unknown
Vital Records,	0 - 0	Completed						24a. Was an autopsy perform	prior to c death?	topsy findings available completion of cause of
g	ilcian: Th certificate rector, pag	0	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2	No 1 ☐ Yes	2 No
	8 <u>.</u>	To B	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3□ DOA Oth	oc.	100-00	nce 6 Other (Spec	ify)
on of	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	y at k? Yes 2 □ No	28d. e e hov	v injury occurred	
Division	or Attendi after death. Director: A I in by the fu	Certification:	2' Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str			28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
<u> </u>	ours ours peral filled		29a. Certifier 1 Certifying Phys	ilcian: To the best of my k	nowledge, death	occurred at the tim	ne, date and place	e, and due to the car	ise(s) and manner as	stated
	To the Hos within 24 h To the Fur completely	Aedical	(Check only 2 Medical Exemin	ner: On the basis of exami and manner stated.	nation and/or in	vestigation, in my or	pinion, death occ	urred at the time, da	te and place, and due	to the cause(s)
	with To	Σ	29b. Signature and little occurrifier	mo		29c. License	JACCO TO TO	29	d. Date signed (Month	, Dey, Year)
5			30. Name and addr s. of erso o co	mpleted cause of death (It	em 23aj) (Ţype,	Print)	7030	0 0	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Λ.ΛΛ
X			Souph TV:	GRASSO	145	E. CM	rrove.	St SHI	15BUPY	(MX)
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 1 6 20	32. Registrar's Sig	nature 4	Spork	2		,	

			For State Registrar	State	of Marylar		artment of He rtificate of D		Mental Hygie	6000	03140
	Physicia	an	Decedent's Name (First, Middle Kenn	, Last) eth Rodei	ahie McM	hillen	Sr			Day Year	3. Time of Death
	/Medic		4a. Fecility Name (If not institution			urren,	4b. City, Town, or	Location of Deat		23, 2004 4c. County of Dea	3:00 a M
€	CXAIIIII	e,	Residence: 456			1	Port	Deposit	=		Cecil
	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, Ye	9. Biri	hplace (State or Foreign
[	Director		213-20-2284 Usual Residence of Decedent	1 M 141 2 1	82	Yrs.			July 11,	1921	Maryland
land	Mo m		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
Man	filed filed	ţo	Maryland	Cecil			Port	Deposit			1 ☐ Yes 2 🎇 No
ith the	or 28	Directo	10e. Street and Number				10f. Zip Code		10g.	Citizen of What Co	
death with the Maryland	s 23s		456 Linton Run			0 10		904		U.S.A	-
	*natural; or liems 23a or 28a-f show edical Examiner must be notified at	Funerai	11. Marital Status  1 □ Never Married 2 ☒ Marri	Armed F ed 1 ∑Yes	2 🗆 No		Was Decedent of His If Yes, specify Cubar		to Rican, etc.)	Black, Whit	
-UUSO hours after	Pal', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	ive ·	2-45	1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
2 0	natur	Completed	15. Decedent (Specify onfy highes	's Education t grade completed	)	16a. Dece	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of wor	rking Ab	o. Kind of Business erdeen Prov	
within	than	ф	Elementary/Secondary (0-12) Ten Years	College	(1-4or 5+)		ctronic Te			erdeen,	Ü
D	od other evsnt, II		17. Father's Name (First, Middle, I	ast)					ne (First, Middle, Mai		in the state of th
ylan ould be	\$ D 9	To Be	Norman	Hazlett	McMuller	n			Kathryn	Stetter	
Maryie d 2 should	th and Men 7 is marke traumatic		19a. Informant's Name/Relationsh		,				ıral Route Number, Ci	-	
6, <b>7</b>	= 44 F		Ruth G. McMulle	n (wife		-			Port Depos	it, Maryl	
	nt of Hea : If item or othe	1.00	20a. Method of Disposition 1 X Burial 2 Cremation				sition (Name of matory or other place				
<b>Saitin</b> Sermit. Pa	등 분 분		* 4 ☐Donation 5 ☐ Other (Sp 21. Signature of Funeral Service I		51		s Cemeter  Name and Address		27/04 Pe	rryville	, Maryland
g g	Depa Impo any Ir		Thomason, M.	talin	ar. Sr.	L	ee A. Pati	terson &	Son Funer nd 21903-	al Home,	P.A.
			23a. Pert1. Enter the disease, or shock, or heart failure. List	complications that	caused the deal	h. Do not ent	er the mode of dying	, such as cardiad	or respiratory arrest,		Approximate Interval Between
	ysician		Immediate Cause (Final disease or condition	_a_1/1	row c	Obs	tructiv	e Bul	movery		Onset and Death
	Medical caminer		resulting in death)	Due	lor as a consec	quence of):		1	Ludor d	ease	
		-er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. e to	o (or as a consec	uence of):	,			4	
petno	nd ransit	Examiner	that initiated events	· Ov	ternos	rlano	tu Car	diovos	ulor d	iseosi	3
, O.	oian ar urial-t		resulting in death) Last	Due to	o (or as a consec	quence of):					
D&/DU	physician and s the burial-transil	edicai		d							
X	attending for use as		IF FEMALE: 23b. Was decedent pregnant		utcome of pregn					23d. Date of del	ivery
. 8	e atte	by Physician/M	in the past 12 months? 1 \( \text{Yes}  2 \( \text{No} \)		birth 2 ☐ Feta gnant at time of c		Ectopic pregnancy Other (specify)			Month	Day Year
that the	by the	Phys	9 Unknown			tal - 1 - at		- 12 B- 24	22a Did tabaa		the cause of death?
တ် အ	been signed by the should be detached		Part II. Other significant condition	ns contributing to	death but not res	suiting in the u	nderlying cause give	n in Part I.	1 ☐ Yes	\	
ecord law requir	peen	Completed							24a. Was an	24b Were au	itopsy findings available
The law	has le 2	duic							autopsy performed	prior to	completion of cause of 2 □ No
	certificate rector, pag	Be C	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes 2ÃΩ ath (Check only one)	INO TES	2 NO
> is	this cer al direc	To B	examiner? 1 ☐ Yes 2 🂢 No	Hospital: 1	Inpatient 2	ER/Outpatier		4   Nursing H	lome 5X Residence	e 6 □Other (Spe	cify)
_ 0	9 9		27. Mannenof Death Natural 5 ☐ Pendin	g (Mo	e of Injury onth, Day Year)	28b. Time o Injury	Work		28d. Describe how i	njury occurred	
DIVISION 1 or Attending	death ctor: , , the f	licat	2 Accident investig	not be	e of Injury - At h	ome, farm, str	eet, factory, office	es 2□No	28f. Location (Stree	t and Number or Ru	ıral Route Number,
בר בר בר בר בר בר בר בר בר בר בר בר בר ב	after I Dire	Certification;	4 Homicide determ	buil buil	ding, etc. (Speci	fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, S	tate)	
tospit	within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	edical (	(Check only 2 Medical	Examiner: On the	basis of examina	owledge, deat	h occurred at the tim- vestigation, in my op	e, date and place inion, death occu	e, and due to the cause arred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
the	thin 2 the l	Med	one) 29b. Signature and title of certifier		nner stated.		29c. License	number	. 29d.	Date signed (Mont	h, Day, Year)
7	¥ ₩ 8		1971.	. M.D			10	2066		123	600
1.	+1		30. Name and address of person	who completed ca	use of death (Ite	n_23a) (Type	Print)	1 0	1 01	1	
V			J Lee	MID.	66	1 K	Evolell	1'ou 5	To stary	e dea	voice M
	Sta Registr		31. Date filed (Month, Day, Year)	#	Registrar's Sign	ature Son	anti)				21078

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:40 P M January 12 2004 Frieda Smithwick McKay /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bowie Prince George's 16311 Pond Meadow Lane 9. Birthplace (State or Foreign Country) S. Carolina If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 🗓 F 10,1934249-48-2753 69 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Mudical Examiner roust be mutified at 1 XYes 2 No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16311 Pond Meadow Lane 20716 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 TNo If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) Cotlege (1-4or 5+) 5+ Public School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ed bluods Joel Alexander Smithwick Janie Marie Littlejohn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clair Albert McKay / spouse 16311 Pond Meadow Lane Bowie, MD. 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 

Burial 2 □ Cremation 3 □ Removal from State 0 = 6 permit. Page Department of important: if any injury or once. 1-19-2004 4 ☐ Donation 5 ☐ Other (Specify) McKay Cemetery Switzerland Co., IN 22. Name and Address of Facility Beall Funeral Home 21. Signature of Fureral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bowie, MD. Approximate Interval Between Onset and Death Imphoma Immediate Cause (Final **Physician** 7 Year disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner nding physician and use as the burial-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2. TNO 3 Probably 4 Unknown 1 ☐ Yes pinous peeu 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has certificate 1 Tes 2A No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \( \tag{Nursing Home} 1 ☐ Yes 2 No ٩ 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After t or Attending 1 Natural 5 Pending investigation death. 1 TYes 2 No 2 Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Pate signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FUGUE CPLOVICUI NO 900 BESTORTE Rd. AUNOPOLIS, Wed. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician 2004 Mary L. Marshall Jan. 8, 6:25 PM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 4182 Suitland Road Suitland Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Wash., D.C. 6 Sex **Funeral** Deys Hours 1□M 257 F 578-56-7317 60 Yrs. Director Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours effer death with the Marylend nent of Heelth end Mentel Hygiene. Int: if them 27 is marked other than "natural", or items 23s or 28s-f show 10a. Stete 10b. County 10c. City, Town or Location 7 is merical other than "natural", or items 23s or 28s-1 show traumetic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 XYes 2 No Director Md Prince Georges Suitland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4182 Suitland Road 20746 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 Specify: B1ack 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Sale Operator Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Melvin Riley Marie Faunteroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $4190 \ \mathrm{Suitland} \ \mathrm{Road}$ Renee Allen (Daughter) Depertment of Heelth Important: If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20746 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial 01/15/04 Landover, Md. 21. Signature of Auneral Service Licenses 22. Name and Address of Facility Ralph Williams Funeral Service 767 1813 Potomac Ave., SE; Wash., DC 20003 23e. Part1. Enter the diffeese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** -/Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine ettending physician end for use es the buriel-trensit requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate hes b lirector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 25ki No 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth Certification: 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. cai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) Robert 2150 ma 0 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State 1 4 2004 Registrar

DHMH 16 Rev 6/95

	1	For State Registrar		Ce	rtificate of	Death		eg. No.		T
siciar edica	1	1. Decedent's Name (First, Middle, Las Estelle Mil	n ler				2. Date of Dea Month 01	Day 06	Year 04	3. Time of Death 4:37 P.1
nine		4a. Facility Name (If not institution, give Laurel Regional			4b. City, Town, LAure	or Location of Dea	ith		nty of Death .nce G	eorges
al or		3/9-30-629/	7. Age (In yrs	s. last birthday) Yrs.	Months Days		. (Month, Day	Year)		place (State or Foreigntry)
		Usual Residence of Decedent  10a. State 10b. County  MD Prince G		City, Town or Lo	ocation					10d. Inside City Limit
Ance.		10e. Street and Number 9000 Briarcroft	Lane		10f. Zip Code 20708	3	1	0g. Citizen o		ntry?
	Dy rur	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. R	ace - Americ lack, White, cify: B1ac	etc.
	Completed	15. Decedent's Ed (Specify only highest gra-		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retin	pation during most of wo	orking	16b. Kind of	Business/In	dustry
á	lo Be Col	8th. 17. Father's Name (First, Middle, Last) Unknown			Domest		ame (First, Middle, i	Self E Maiden Sum		<u>ed</u>
		19a. Informant's Name/Relationship (7) Selma L. Greenfie					Rural Route Number			Code)
		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  1 ☐ Other (Specify	Hemovan nom State		osition (Name of matory or other pla ashingto:	·		20c. Location		own, State
SUCE		21. Signature of Funeral Service Licen		2:	2. Name and Addr	ess of Facility MA	Arshall's Washing	Funer	al Hor	
n il er		23a. Pagi. Enter the disease, or companion, shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	b. Due to (or as a conse	equence of):	ter the mode of dy	ing, such as cardia	ac or respiratory arr	est,		Approximate Interval Between Onset and Death
13	cal Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. PNEUMONIA  Due to (or as a conse			**** *** *** *** *** ***				
Mario la la Mario	rnysician/medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[	⊒Ectopic pregnand □ Other (specify) _	ey .		1	Date of delive Month	ery Day Year
1	ò	Part II. Other significant conditions of FUNGEMIA	ontributing to death but not re	esulting in the u	underlying cause g	ven in Part I.		_		he cause of death? pably Kounknow
	Сошріете	RENAL FAILURE					24a. Was a autops perforr	ned?	o. Were auto prior to co death? 1 \(\sum \text{Yes}\)	psy findings availab mpletion of cause o
e e	lo De	1 1 1 1 1 2 2 X	1 43	☐ ER/Outpatie		her: 4 \( \text{Nursing} \)	eath (Check only on Home 5 Reside	ence 6 🗆 C		y)
100000000000000000000000000000000000000	ertification	27. Manner of Death  1 X Natural  2 Accident  3 Suicide  4 Homicide  5 Pending investigation 6 Could not be determined		28b. Time of Injury home, farm, st	M 1 [	Yes 2□No	28d. Describe ho	reet and Nur		al Route Number,
	Medical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my ki iner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	th occurred at the to evestigation, in my	ime, date and plac opinion, death occ	e, and due to the courred at the time, d	ause(s) and i ate and place	manner as s e, and due to	tated. the cause(s)
	Me	29b. Signatur Pld title of certifier  8 Pley Cerv	10 AHENDI	19.	29c. Licen D42	se number	2	9d. Date sign		Day, Year)
/		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type.	Print)	3				

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	8	T.	1 - For State Registrar		ryland / Dep		lealth and M	lental Hyg		004	03141
П	Physici	an	1. Decedent's Name (First, Middle, Last)  JOE MAT	THEWS				2. Date of Deat Month	Day	Year 04	3. Time of Death 5: 05 P M
	/Medio		4a. Facility Name (If not institution, give :	street and number)		4b. City, Town, o	or Location of Death			y of Death	
			Prince George's Hospi  5. Social Security Number 6.		(In yrs. last birthday)	If Under 1 Year	everly If Under 24 Hrs.	8 Date of Birth			·
À	Funeral Director			M 2□F	57 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, June 17,	1946	Nort	place (State or Foreign ntry) h Carolina
	e Maryland	ctor	10a. State 10b. County  Maryland Prince Geo	orge's	10c. City, Town or Lo		al Heights			1	0d. fnside City Limits 1 □XYes 2 □ No
	th with th	al Dire	10e. Street and Number 510 62nd Place #D			10f, Zip Code	20743	1	0g. Citizen of U.S.		ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show enty injury or other traumatic event, the Medical Examinar must be multiled at ance.	Completed by Funeral Director	11. Marital Status  XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1XXYes 2 ☐ N If Yes, Give Year or Dates:	ever in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ₩ o	dispanic Origin? (Spe an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	Bla	ce - Americ ick, White, fy: Blac	etc.
21215-0036	within 72 ho ane. than *natur	mpleted	15. Decedent's Edu (Specify only highest grade	cation e completed) College (1-4or 5	+) (Give		during most of work d)	ing	16b. Kind of B		dustry Orce Base
Maryland 2	uid be filed Aental Hygir rked other tic event, L	To Be Co	12th grade 17. Father's Name (First, Middle, Last) Malachi Matt	thews	Ja	IIIOHAI S	ervice (Engin 18. Mother's Name Je		Maiden Sumar J	me)	
	and 2 sho salth and h n 27 is ma		19a. Informant's Name/Relationship (Ty.) Jeanette Matthews (Sis		6609	Netties Lar	and Number or Rura ne #1507 Ale	xandria, V	/irginia	2231	5
Baltimore,	permit. Pages 1 Department of He Important: If Iten eny injury or oth		20a. Method of Disposition  1XXBurial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	20b. Place of Dispo cemetery, cre Mary Land V	osition (Name of matory or other pla eterans C	ce) emetery 1/16	1	20c. Location heltenh	•	
Balt	permit. Departi Import. eny inj pace.		21. Signatur of Funeral Septe License	Inde		2. Name and Addre 339 HINT P	ess of Facility RO	LLINS FUN INGION, D			•
72	Physician /Medical		23a. Park. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	END ST	AGE ^a consequence of):	1ETAST	ATIC C	ANCE	R		Approximate Interval Between Onset and Death 5 YrS
760,	icate be executed  physician and sthe burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	RE CA a consequence of): a consequence of):	CHEXII	A AND	MALN	UTRIT	1010	2 442
.O. Box 68	The law requires that the death certifica Ite has been signed by the attending phy tage 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 to 1 to 1 to 1 to 1 to 1 to 1 to 1	2 ☐ Fetal death 3 ☐	□Ectopic pregnanc □ Other (specify) _	у		1	ate of delive	ory Day Year
<u>а</u>	w requires that been signed by should be deta	b	Part II. Other significant conditions con	ntributing to death bu	it not resufting in the u	nderlying cause gn	ven in Part I.	23e. Did tob			ne cause of death?
Vital Records,		Completed						24a. Was an autops perform	ned2	prior to cor death?	psy findings available mpletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospitaf:		at 30 DOA Ott	26. Place of Death	(Check only on	э)		
o	S S	n: To	27. Manner of Death	28a. Date of Injur	y 28b. Time o	f 28c. Iniui	v at	me 5 ☐ Reside 28d. Describe ho			1)
Division	Attending or death. ector: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, farm, sti		Yes 2□No	28f. Location (Str.		ber or Rura	l Route Number,
Ö	To the Hospital or Attending Phaining 2 the 24 hours after death. To the Funerel Director: After the completely filled in by the funeral		29a. Certifier 1 <b>♂ Certifying</b> Phys	building, etc	of my knowledge, deat examination and/or in	h occurred at the til	me, date and place, a	City or Town	iuse(s) and m	anner as st	ated.
ı.	To the H ithin 24 To the F complete	Medical	29h Signature and title of certifier	and manner sta	ted.	29c. Licens	se number	20	ad Date signe	d (Month	Day Yearl
	(2)		30. Name and address of person who con FARHAD JAMALS	JULIANA OF de	eath (Item 23a) (Type,	DO Print)	05821	00 110 3	001 H	Spile	JOY _
	Sta	ite	EARHAD JAMAL   31. Para filed (Months Para Kear)	MD, De	pt. of IN	TERNAL N	IED ICINE, 1	PG-HC, CI	neverly	MD	20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registral END ITEM #8 PER FI: G828 2/24/04 Jh Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William M. Manus pour 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner & cores queen's Cha Butch Homee net MT-AhI If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 1-11-1928 9. Birthplace (State or Foreign Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Months 579-30-1029 76 Director North Carolina Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show such be notified at 1 Yes 2 □ No Directo Maryland Prince George's Mt. Rainier 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 3149 Queens Chapel Road or Items 23a 20712 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give 14. Bace - American Indian 11. Marital Status other traumatic event, the Mudical Extrainer :-Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 File Clerk Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Heelth and Mental item 27 is marked o Perry Manus Merle Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Manus - Brother 510 View Field Dr., Salisbury, Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State jo = 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 3 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department of Important: If ony injury or Metropolitan Crematory 1/15/04 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. audette\_ 4739 Baltimore Ave., Hyattsville, MD 20781 moc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Im Heart Disease Atherisc **Physician** eritiz /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai as the l IF FEMALE: esn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has autopsy 1 Yes 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 6 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injun 1-Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours. To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar (Check only

29b. Signature and title of certifier

Sylva 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signa JAN 1 6 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHIVIR 17 Rev 1/2001

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Tal

29c. License number

Drive

HOUS 377

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artmen ertificat			and Me	_	jiene log. No.	2004	03146
	Dhysisi	20	1. Decedent's Name (First, Middle, Las	t)					1	<ol><li>Date of Dea Month</li></ol>	ith Day	Yeer	3. Time of Death
	Physici /Medio		Anthony Joseph N							January		2004	7:03 A <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give			1		Location o	of Death			ounty of Death	
7		Н	St. Mary's Nursin		a (la ura laat hirthda		ardt 1 Year	OWN	24 Hrs 6	8. Date of Birth		. Mary	
ųž:	Funeral		5. Social Security Number 6. Se	M 2□F	e (In yrs. last birthday Yrs.	Months		Hours	Min.	(Month, Dey	r, Year)		place (State or Foreign Intry)
	Director		220-32-5384 Usuel Residence of Decedent		67 113.					Nov. 24	19.	36 Mary	/land
	yland		10a. State 10b. County		10c. City, Town or L	ocation		-					10d. Inside City Limits
	a-f s	ctor	Maryland St. Mary	y's	Scotland								1 ☐ Yes 2 ☑ No
	or 28	)ire	10e. Street and Number			10f. Zip	Code				10g. Citize	n of What Cou	untry?
	ath w	ra	49321 Harry James			206					USA		
	er de	by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		. Was Dece	dent of Hi cify Cuba	ispanic Orig n, Mexican	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)	14	. Race - Amer Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>M</b> If Yes, Give Year or Dates:	NO	1 🗆 Yes	2 <b>X</b> No	Specify:			S	pecify:	1+0
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-f show the Molical Exercites mail be notified at	ed	15. Decedent's Ed	lucation	16a. Dec	edent's Usu	al Occupa	ation			16b. Kind	Whi of Business/l	
215	nin 7.	pie	(Specify only highest gra	de completed) College (1-4or :	14.2	e kind of wo DO NOT u					-		
21	giene er th	Completed	Elementary/Secondary (0-12)		Hea	avy Eq	uipm		<u> </u>			nstruct	10n
b	al Hy doth	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden S	umame)	
yla	Ment Ment arke	L <sub>o</sub>	Charles I. Norr							len Rid			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Modical Examins in all the notified at Once.		19a. Informant's Name/Relationship (7	, ,		•	,					Town, State, Zi	ip Code)
	1 and 1ealth em 27 ther tr		David N. Norris /	Son	20b Place of Disc	osition /Na	me of		Land	, Maryl		2000 / ation - City or 1	own State
Baltimore,	Pages Jent of thint: If its		1 ■ Bunal 2 □ Cremation 3 □		cemetery, cri	ematory or o	other plac						
Hi	it. Partmer		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		St. Micl							e, Mary	nland ome, P.A.
Ba	permit. Departn Importe any inju		March 17	- MO	/   { /							own, MI	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	Dications that caused one cause on each li				g, such as	cardiac or		rest,		Approximate Interval Between Onset and Death
*	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequence of):	1		( )	VO		USC	000	
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. ————————————————————————————————————	a consequence of):								
8760,	cate be executed oblysician and the burial-transit	ical Exa	that initiated events 'resulting in death) Last	Due to (or as	a consequence of):								
687	ficate p phys	edic		d									
O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetel death 3	□Ectopic p □ Other (sp					23	d. Date of delin	very Day Year
Q.	that i		Part II. Other significant conditions c	ontributing to death b	out not resulting in the	underlying o	ause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
Sp.	uires sign	d by								1 🗆 Y	es 2 🗆	No 3 ☐ Pro	bably 4 Unknown
Records,	w req	Completed								24a. Was a	an	24b. Were aut	opsy findings available
Re	he la e has age 2	E C								autops	med?	prior to death?	ompletion of cause of 2 ☐ No
Vital	an: T tificat tor, pa	0	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only or	2No	1 103	2 140
Ξ	ysici is cer direct	To B	examiner? 1 Tes 2 No	Hospital: 1   Inpatio	ent 2 ER/Outpatio	ent 3 DC	Othe					Other (Spec	ify)
J Of	ng Ph ter th neral		27. Manner of Death  1. Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time	of :	28c. Injun			3d. Describe h			
Sio	Attending r death. actor: After by the fune	atic	2 ☐ Accident investigation	1		М		Yes 2□I	No				
Division	tal or Att rs after d al Diract ed in by I	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Flace of in	ury - At home, farm, s ic. <i>(Specify)</i>	street, factor	y, office		28	3f. Location (S City or Tow		Number or Rui	ral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)  Certifying Ph	ysician: To the best niner: On the basis o and manner st	of my knowledge, dea of examination and/or ated.	nvestigation	i, in my o	pinion, dea	d place, ar th occurre	d at the time, o	late and p	lace, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier					e number	~ ~			signed (Month	
			1	Shal	1			H7c	66		1-	22	.04
3	1200		30. Name and address of person who										
			Avani D. Shah,		50 Cedar L rar's Signature	ane C	ourt	, Leon	nardt	own, Ma	aryla	nd 206.	50
П	Sta Regist	ate	IAN 2.3	2004	ai 3 Signature	Società	D						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 State Registrar Amend Item#12perFHG828 2/21/04 EW Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:58 A M M. NECLOS **Physician** (SARY 04 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FORT WASHINGTON, MD PRINCE GEMGES FORT WASHINGTON HOSPITCAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O \$ / O 9. Birthplace (State or Foreign Nash D.C. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1⊠M 2□F 48 578-72-0273 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location worde 10a State 10h County is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. It has not a 72 in marked other then "natural", or flams 23s or 28e-1 show other traumatic event, the Medical Examiner must be fittillised. 1 ☑Yes 2 ☐ No MD PLINCE GEORGES OXON HILL Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number DUDLEY JUENUE UCA 20745 1018 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AUTO MECHANIC PRIVATE 10TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JAMES VINCENT NECLOS GERALDINE HOWARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PATRICIA BUCHANAN / SISTER 6918 DUDLEY AVENUE OXON HILL, MD 20745 Baltimore, Normic Peges 1 and Devenment of Health Important: It item 27 eny longer to the run. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial XX Cremation 3 Removal from State METROPOLITAN CREMATORY 16 JAN 2004 ALEXANDRIA, VA \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenset MARSHALL'S FUNERALHOME OF MARYLAND, INC. Maris 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE **Physician** JECUS /Medical Due to (or as a consequence of): eaus Examiner Y PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physicien and for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SLEEP APNEA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CHRONIC OBSTRUCTWEPULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☑ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27 Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel ti Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D56005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11711 LIVINGSTON RD. PT. WASHINGTON, MD 20744 StUMN R. O'MARA, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - For State Registrar	State of Ma		Depa	artme		lealth and		l Hygi		004	03	145
П	Physici	an	Decedent's Name (First, Middle, Last)							Mor	of Death	Day	2004	3. Time o	
	/Media	cal	Marvin Melvin  4a. Fecility Name (If not institution, give	Nimmo			45 C	h. Tourn o	Location of Dea	Jan	n. 1	.0	2004 inty of Death	1:00	ЭРМ
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	Funeral		Social Security Number 6. Sex		(In yrs. last i	birthday)	If Und	der 1 Year	If Under 24 Hr	s. 8. Date	of Birth		0.00		or Foreign
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	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation				-		1	0d. Inside 0	City Limits
	Maryl fehc	to	MD Anne Arun	nde1	•	Eda	ewa	tor							s 2 No
	r 28a	Director	10e. Street and Number	idei		Lug	_	Zip Code			10	g. Citizen	of What Cour	ntry?	
	th with	ai D	3874 Holly Drive					2103	37				USA		
	should be filed within 72 hours after death with the Maryland Menial Hygiene. Tharkad other than "netural", or Items 23a or 28a-f ehow imatic event, the Mudical Examira manal be notified at	Funeral	11. Marital Status	12. Was Decedent E- Armed Forces?		13. V	Vas De	cedent of H	ispanic Origin? ( in, Mexican, Pue	Specify Yes	or No-		Race - Americ		
36	or It	by Ft	1 ☐ Never Married 2 1 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give 1	060 71	,		2 No	Specify:				cify: Whi		
Maryland 21215-0036	tural	ed t	15. Decedent's Edu	Year or Dates: 1			lent's U	sual Occup	ation		14		f Business/Inc		
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nd	be filed htal Hygie td other	Be	17. Father's Name (First, Middle, Last)						18. Mother's Na				ame)		
yla	should Ind Meni	ို	William Allen Nim						Estell					-	
Mar	2 4 5 4		19a. Informant's Name/Relationship (Ty)	*	19				and Number or R						
	1 and Health em 27 ther tr		Barbara L. Nimmo /	spouse	20b. Place cemei			lly Di Iame of		dgewa			21037 on - City or To		
آ ا	Pages nent of I ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	temoval from State	MD. V				1	15 20					
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License	<b>*</b>	TID. V				is of Facility $\dot{\mathbb{B}}$	15-20 eall			sville ome	, MD.	
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rds, P	The law requires that the te has been signed by th age 2 should be detache		Part II. Other significant conditions con	tributing to death but	not resulting	in the un	derlying	cause give	en in Part I.	230	Did toba		ontribute to th		death? Unknown
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				Otho	26. Place of De		4				
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DIVISION	or A after Direction by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, (Specify)	farm, stre			30 20.00		tion (Street or Town, S		mber or Rural	Route Num	ber,
	Hospital 14 hours a Funeral I		29a. Certifier 15 Certifying Phys	sician: To the best of	my knowled	ge, death	occurre	d at the tim	e, date and place	e, and due t	o the caus	se(s) and	manner as sta	ated.	
		Medical	one) A	and manner state	id.	or inve				urred at the					,
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r	والما لك	1	30 Name an laddress of person who con	mpleted cau of dea	th (Item 23e	SEST SEST	GA	JE1	RD 300	AW	APIZ	15 M	0212	tol	
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			1 - For State Registrar	State of Maryla	and / Dep		of H	ealth a	nd Me	Re	ene 2 (	001	0315
	- Physici	an	Decedent's Name (First, Middle, Last)							Date of Death Month	Day	Yeer	3. Time of Death
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9	Examir	er	Casey House	street and number)			ckv		Doam				gomery
	Funeral		5. Social Security Number 6. Sex		rs. last birthday,	If Under 1	1 Year	If Under 2	4 Hrs. 8	. Date of Birth (Month, Day,		9. Birth	place (State or Foreign
В	Director		578-24-1105	M 2DXF 79	Yrs.	Months	Days	Hours	Min.	ct. 6,	1924		hington, D
	pue *		Usuel Residence of Decedent  10a. State 10b. County	10c.	City, Town or Le	ncation							10d. Inside City Limits
	Aaryli aho	ō	Maryland Montgom			ilver	Snri	na					1 X Yes 2 No
	28a-	rect	10e. Street and Number	CLY		10f. Zip (		ing		100	g. Citizen of V	What Cou	untry?
	3a or	O	2904 N. Leisure	World Blvd	#304			906			U.S.		•
	death	nera		12. Was Decedent Ever in Armed Forces?		Was Decede			in? (Speci	fy Yes or No- can, etc.)	14. Rac	e - Amer	icen Indian.
9	or Ite	F	1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2			Puerto Pik	can, etc.)		ck, White	, etc.
8	within 72 hours after death with the Maryland ene. than 'natural', or Iteme 23a or 28a-1 ahow ta Mwulcal Exami'sr musi be nutified at	Completed by Funeral Director	3 Widowed 4 Divorced	Year or Dates:				*****			Specify	Wh	ite
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ם מ	Hyg other	Be C	17. Father's Name (First, Middle, Last)			Homom			's Name (/	First, Middle, Ma			
lan	fental fental rked ric ev	To B	Vincenro Marce	llino				Sa	lvatr	rice (U	navai1	able	2)
ary	shor and M e mai		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Maili	ng Address (	Street a	and Number	or Rural P	Route Number, (			•
Σ	and 2 salth in 27 I		Anthony Vincent Na					Lane	, Owi	ngs, MD	2073	36	
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		<ul> <li>Place of Dispo cemetery, cre.</li> </ul>	osition (Name matory or oth	e of ner place	9)	Dat	9 20	c. Location -	City or T	own, State
Ē	ment ment: lury c	١.	`4 □ Donation 5 □ Other (Specify)	Fo	rt Lincol		_		1/14/2				Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Item 27 is marked other than *natural; or iteme 23a or 28a-f ahow amportant: in Item 27 is marked other than *natural; or iteme 23a or 28a-f ahow injury or other traumatic event, its Medical Examination must be nutified at ORCE.		21. Signature of Funeral Service License	21 1	2: -mingst7	2. Name and [39 Ba]	Addres Ltim	s of Facility ore Av	Gasch venue	's Fune , Hyatt	ral Ho sville	me,	P.A. 20781
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that ceused the de e cause on each line.	eath. Do not en	ter the mode	of dying	g, such as ca	ardiac or r	espiratory arres	t,		Approximate Interval Between
	Pnysician	n i	Immediate Cause (Final disease or condition	Metastatic	Breast	Cance	er						Onset and Death 6 Months
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):								
3		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to for as a sons	aniene offi							_	
	nsit	Examiner	Cause (Disease or injury	200 10 (01 20 20 00 00	3,7								
o.	te be executed ysician and te burial-transit	Еха	that initiated events cresulting in death) Last	Due to (or as a cons	equence of):								
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89	diffica ng ph as th	Med	IF FEMALE:							Jav.	111		ne diamento
Box	ath ce ttendi	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		∃Ectopic pre	gnancy				23d. Date Mor		
o.	The law requires that the death certifica tie has been signed by the attending ph rage 2 should be detached for use as th	Physician/Med	1 Yes 2 No	4☐ Pregnant at time o 9☐ Unknown	f death 5	Other (spec	cify)				Moi	1(11	Day Year
ď.	hat the	Ρh)	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying car	ISA GIVA	n in Part I		23e Did toba	cco use contr	ibute to t	he cause of death?
ds,	signe d be	d by	Chronic Pleural H			, ioony arg out	acc give	**					pably 4 Unknown
Ö	w requir been si should I	Completed			<del></del> -					24a. Was an			
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<u>a</u>		e Cc	25. Was case referred to medical					00 Din	-4 D45 - 6	1  Yes 2 2	No 1	□Yes	2□ No
>	ysicia s cert direct	0 8	avaminar?	ospital: 1   Inpatient 2	☐ ER/Outpatier	at 3□ DOA	Othe			Check on one 5 □ Besiden	e 6Mi∩the	ar /Sneci	y) Hospice
Ö	g Phys er this eral di	n: T	27. Menner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time o		c. Injury Work	at		Describe how			у, позрісе
ō	Attending Physician: r death. sctor: After this certific; by the funeral director,	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 1991)	Injury	М		es 2□No	0				
Division of Vital Records,	el or Attens safter deat l Director: d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	reet, factory,	office		28f	Location (Stree City or Town, S		er or Run	al Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Directompletely filled in by	edical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my k ler: On the basis of exami and manner stated.	nowledge, death nation and/or in	h occurred at vestigation, i	t the tim n my op	e, date and inion, death	place, and occurred	due to the causat the time, date	se(s) and mar and place, a	nner as s	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of conflien			29c.	License	number		29d	. Date signed	(Month.	Day, Year)
			affect)				)d	D4	1121	8	1/12	10	4
)	(5)		30. Name and address of rson who con	mpleted cause of death (It	em 23a) (Type,	Print)	00	111			1	1	1
			Charles Harrison,			er Mil	⊥ Ro	oad, R	lockv:	ille, M	2085	55	
	Sta Registr	17	JAN 1 4 2004	22. Registrar's Sig	nature	B							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For 1-21-04 State of Maryland State of Maryland #1.Per Phys.PGC cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician CHARLES EDWARD NICHOLAS Yeer CHALRES EDWARD NICHOLAS JANUARY 12, 1:53P M 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth CLINTON

or 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) SOUTHERN MARYLAND HOSPITAL CENTER PRINCE GEORGES If Under 1 Year Months Days 5. Social Security Number 6. Sex XX M 2□ F 7. Age (In vrs. last birthday) **Funeral**  Birthplece (State or Foreign Country) Months Director 231 40 5764 66 MAR. 07, 1937 VIRGINIA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County or 28a-t show 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show with injury or other traumatic event, the Mudical Examiner must be notified at once. Directo XX Yes 2 No MARYLAND PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5916 WOODLAND LANE 20735 Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **XX** No If Yes, Give Year or Dates: 11. Marital Status 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 16TH College (1-4or 5+) SCAFFOLD BUILDER PRIVATE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) TINKNOWN ANNIE NICHOLAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY NICHOLAS (WIFE) 5916 WOODLAND LANE CLINTON, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Weurial 2 Cremation 3 Removal from State \*4 □Donation 5 □Other (Specify) HARMONY MEMORIAL PARK 01/17/2004 LANDOVER, MD 21. Signature of Funeral Service Licensee MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that be used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** monor /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical End Stage IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division of Vital within 24 hours after death. To the Funerel Director: A Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) e, mo D46895 3710 Riviera St, G4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Telele Temple Itills, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 5 2004 Registrar

(B)

			For 1 State	State of Mar	yland / Dep	ertificate of	lealth and N		annual and other	4 03/52
			Registrar  1. Decedent's Name (First, Middle, Las	et)		runcate or i	Dealin	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia	an	Constant Control of the Control of t		Brien			Month JANUAR	Y 21,2004	
	/Medic		Daniel More  4a. Facility Name (If not institution, give		ргтеп	4b. City, Town, or	r Location of Death		4c. County of D	
6	Examin	eı	12300 CHERRY TREE		ROAD	CLINT	ON		PRINCE	GEORGES
	Funeral		5. Social Security Number 6. S	ex 7. Age (	In yrs. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h year) 9.	Birthplace (State or Foreign Country)
H.	Director		214-49-9908	®M 2□F	22 Yrs.	Month's Days	Tiodis Iviii.	July 7,	1981 Br	azil
	pu ,		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or I	ocation				10d. Inside City Limits
	aho	ī								1 ☐ Yes 2  No
	the M	Directo	Maryland St. Ma	ary's		Calla	way		10g. Citizen of What	Country?
	a or									osam,
	eath	Funerai	21200 Point Lool	12. Was Decedent Ev	er in U.S. 13	. Was Decedent of H If Yes, specify Cuba	0620 Iispanic Origin? (Sp	pecify Yes or No-	Brazil 14. Race - A	merican Indian,
10	fter d	Ξ	1 Never Married 2 Married	Armed Forces? 1   Yes 2 □ No						/hite, etc.
93	or's a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 des 2 □ No	Specify: Bra	zilian	Specify: W	hite
2-0	be filed within 72 hours after death with the Maryland hat Hygiene od other than "natural", or tems 23a or 28a-f ahow event, the Medical Ezart and must be traffied at	Completed	15. Decedent's Ed (Specify only highest gra		(Giv	edent's Usual Occup	during most of work	king	16b. Kind of Busine	ss/Industry
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<u>n</u>	be fill pd ott	Be	17. Father's Name (First, Middle, Last)							
3	2 should be and Mental la marked aumatic ev	<sup>2</sup>	Ajenor Dasilva	Super Chief	10h Mai	ling Address (Street		zinha Mo		a. Zin Codol
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<u>ب</u>	is 1 and 2 of Health a Item 27 is other trav		Alex O'Brien / I	rotner		D POINT LO position (Name of ematory or other place		ad, Call Date	20c. Location - City	yland 20620 or Town, State
5	ages of of t: If it		1 Burial 2 Cremation 3			ematory or other plac Ld–Echo1s	1	2007	harlatta	u.11 MD
Baltimore,	permit. Pages I Department of H Important: If Ite any injury or ot	- 1	* 4 □Donation 5 □Other (Specify 21. Signature 5 Euneral Section 1	500						Home, P.A.
Ba	permi Depa Impo any it		Edward N. Brinst	leld, Gr.	- Alexander					D 20650-0279
6	W.C		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	dications that caused th	e death. Do not e					Approximate Interval Between
ve 3	Physician		Immediate Cause (Final	one cause on each line.	Anne					Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a a	con (quence of):					
\$	Examiner		One contains the line conditions	b. =	V					
	₽ ≒	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):					
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687	icate phys s the	dic		. d						
Box (	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of	delivery
Ď.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2: 4 ☐ Pregnant at tin		☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
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ī	requires sen sign hould be							1 🗆 Y	es 2 No 3	Probably 4 Unknown
၁၁	<u>ra</u> ≈ c₁	plet						24a. Was a	sv prior	autopsy findings available to completion of cause of
Ä	The ate h page	Completed						perfor	med? death	? 'es 2□ No
Vital Records	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or	ne)	
of V	<b>8</b> ₹	2	1X Yes 2 □ No	Hospital: 1 ☐ Inpatient			4   Nutsing In		ence 6 NOther (S	pecity) SCENE
ū		on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time Injury	Worl		28d. Describe h	ow injury occurred	out.
Division	Attanding r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 □ Could not be	1- 7211	The second secon	1425 10 10	Yes 2 No	394 Location (S	troot and Number of	Rural Ruite Number,
Ξ	after death Director:	Ħ	4 ☐ Homicide determined	28e. Place of Injur- building, etc.	(Specify)	treet, factory, office	0,0	City of Tow	n, State) 12300	Cherry Their
	pital		29a, Certifier 1 ☐ Certifying Ph	ysician: To the best of	my knowledge des	th occurred at the tim	ne date and place	and due to the	Chata M	as stated
	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by	edical		niner: On the basis of ex	xamination and/or i					
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	e number	- 2	29d. Date signed (Mo	onth, Day, Year)
	- 3 - 0		1 Leodare 1	11.16	12	0.0	C.M.E.	JA	ANUARY 22,	2004
			30. Name and address of person who	completed cadse of dea	th (Item 23a) (Type	, Print)				
3.5			THEODORE MIKE	of		111 Penr	Street,	Baltim	ore, Mary]	and 21201
10	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	a don't .				
	Registr	-4	JAN 2 7	2004	- 15 h	Size II				
DH	MH 17 Rev 1/2	UO1			ORIGIN	IAL				

		For State Registrar	State of Maryla		artmer ertificat				F	leg. No.	004	03	53
Physici /Medic		1. Decedent's Name (First, Middle, La Robert Donal	•						2. Date of Dea Month Janua	Day	2004	3. Time of 0	
Examir		4a. Fecility Name (If not institution, given 37500 River Spring)				Town, or venue	Location of	Death			ounty of Death Mary 's		
Funeral Director		5. Social Security Number 6. S 220-32-6453	Sex 7. Age (In your 15	rs. last birthday 7 Yrs.	Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birt (Month, Day June 3	(Year)	9. Birth Cou 36 Mary	place (State or ntry) Land	Foreign
iled within 72 hours after death with the Maryland Hygiene. Wher than "natural", or Itams 23s or 28s-1 show ont, the Madical Exprainter must be natified at	Director	Usual Residence of Decedent		City, Town or L Avenue	ocation	o Code				10g. Citize	n of What Cou	10d. Inside City 1 ☐ Yes	
be filed within 72 hours after death with the Marylan tall Hygiene. Id other than "natural", or Itams 23a or 28a-1 ahow event, the Madical Expiritive must be natified at	by Funeral Di	37500 River Sprin	12. Was Decedent Ever in Armed Forces?	U.S. 13.		0609 dent of Hi cify Cuba	ispanic Origi n, Mexican,	in? (Spec Puerto F	cify Yes or No-	USA	Race - Ameri Black, White,		
hours aft		1 Never Married 2 Married 3 Widowed 4 Divorced	1 M Yes 2 ☐ No If Yes, Give Year or Dates:	16a Dec	1  Yes		Specify:		- 1		of Business/In		
A I A I D-UUS d d within 72 hours af giene. er then "natural", or the wedical Exam.	Completed	(Specify only highest gr Elementary/Secondary (0-12)		(Giv	e kind of wo DO NOT u	ork done d se retired	during most of () nician				Governm		
d is b	To Be Co	17. Father's Name (First, Middle, Last Thomas Edward 01							(First, Middle,		ımame)		
i, Ividiry and 2 shou saith and M n 27 is mar ier traumat		19a. Informant's Name/Relationship (Bernadette Zimme)							Route Number	_	own, State, Zij 0618	o Code)	
Dallillore, Mar ylar ylar permit. Pages 1 and 2 should Obsparlment of Health and Men Important: If tem 27 is marke any injury or other traumatic. Once.		20a. Method of Disposition  20a. Method of Disposition  20a. Method of Disposition  3 Cremation 3 Cher (Special Control of Control o		Place of Disp cemetery, cre acred H	amatani ar	other place	tery <sup>Jar</sup>		13, 2004		tion - City or T		ıd
permit. F Departme Importan any injur		21. Signature of Funeral Septice Lice		M	22. Name a atting	nd Addres Ley-Ga	ss of Facility	Funer	al Home,	P.A.			
Physician /Medical		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	Hus	man	wn	mun	wdo	ficier	ncy l	rindo	Approximate Interval Betw Onset and D	reen reath
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lor Attending Physician: The law requires that the dath.  Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed								24a. Was autop perfor 1 Yes	sy	24b. Were auto prior to co death? 1  Yes	opsy findings a ompletion of ca	vailable use of
VILCA ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	A-1		(Check only o				115
ing Phys	on: To	1 Yes 2 No  27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year	ER/Outpatie	of	28c. Injun Worl	y at k?	2	8d. Describe h			(y)	
i git d	Certification;	2 Accident investigation 3 Suicide 6 Could not 1 4 Homicide determined	De Blace of leiung A	t home, farm, s	M street, factor		Yes 2 □N		8f. Location (S City or Tow		Number or Run	al Route Numb	?e <i>r</i> ,
To the Hospital within 24 hours a To the Funerel I completely filled	edical C		hysician: To the best of my l miner: On the basis of exam and manner stated.										
To th within To th compl	Me	29b. Signature and title of certifier			29	_	e number	37		29d. Date s	signed (Month,		
450		30. Name and address of person who Nirmaladevi Gurus				Road	l, Wal	dorf	, MD 20	602			
Sta Regist		31. Date filed (Month, Day, Year)	32. Registral's Si	gnature	b	will	)						

State of Maryland / Department of Health and Mental Hygiene 2 1 1 | 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Carmen Katherine O'Connor Jamuuary 17,2004 **Physician** 11:45P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Millenimum Health & Rehab. Edgewater Anne Arundel 9. Birthplace (State or Foreign Country) Wash.D.C. tf Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 ☐ M 2 X F 86 Yrs. 21,1917 Director April. Usuat Residence of Decedent 10d. tnside City Limits 10c. City, Town or Location 10a. State 10b. County rel', or Items 23a or 28a-f ehow Exeminer must be notified at 1 ☐ Yes 2/1/No Maryland Anne Arundel Edgewater Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 48 South River Road or Items 23a 21037 USA Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene.
and of Health and Mental Hygiene.
ant: If team 27 is marked other then "neturel", or Items 23, and the content fraumatic event, it as Medical Execution mutal. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates: Specify: White 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph B. Walling Catherine L. Dillon ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carmen C. O'Connor/Daughter48 South River Road, Edgewater, Md. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Kalas Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1-19-04 Edgewater, Maryland permit. Page Depertment of Important: If eny Injury or 2002e. ¹ 4 □ Donation 5 □ Other (Specify) 21. Signal e of Funeral/Sepice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. 2973 Solomons Island Rd. Edgewater, Md. Approximate Intervat Between Onset and Death hemic Condiarry on all Immediate Cause (Final disease or condition 4,05 **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immodiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 Mo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2000 certificate 1 ☐ Yes 2□ No Division of Vital fo the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Warsing Home 5 Residence 6 Other (Specify) Hospital: 1 [] Inpatient 3 DOA 1 ☐ Yes 2 No 2 ER/Outpatient 2 completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Iniury 1 Natural 2 Accident 5 Pendina 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 159 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 3 4 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Loon person with completed cause of death (Item 23a) (Type, Print) 30. Name and address Drive Chister, MD 108 DiD make 32. Raistrar's Signature 31. Date fited (Month, Day, Year) State Registrar

4 – KG	0486		#2 1 = For Amended Item#23a, Registrar	State of M 27,28a-f,Re	larylar er ME,	nd / Dep G828,2/	artmer	nt of H	ealth a Death	and Me	ntal Hy	giene Reg. No	2001	: 03	The state of the s
	Physic	ian	1. Decedent's Name (First, Middle, Last,	)							2. Date of Dea			3. Time o	of Death
	/Medi	cal	Albert Dale Owens  4a. Facility Name (If not institution, give		1		4h City	Tour	Location of		Januar	y 16	5, 2004	11:3	9 P <sup>M</sup>
	Examir	ner	Anne Arundel Medic					apoli		i Death			County of Dee	_	
	Funeral		Social Security Number	7. A	ge (In yrs.	last birthday		r 1 Year	If Under 2 Hours	24 Hrs. 8	Date of Birti	h		thplace (State	or Foreign
4	Director		220-60-1147  Usuel Residence of Decedent	∄M 2□F	50	Yrs.	IVIOITUIS	Days	riodis		July 21	1, 1	953 Pen	nsylvar	nia
	/land		10a. State 10b. County		10c. Cit	ty, Town or L	ocation							10d. Inside C	City Limits
	e-f st	ctor	MD Anne Aru	ındel			Ec	lgewat	ter					1 □ Yes	2 <b>X</b> No
	or 28	Director	10e. Street and Number				10f. Zij	Code				10g. Cit	tizen of What Co	ountry?	
	s 23s	era	827 Mayo Road, #		Commission II	S 40	111 5		037				USA		
36	iges 1 and 2 should be filed within 72 hours atter death with the Maryland to f Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23a or 28e-f show or other treumatic event, the Medical Examiner roust be motified at	by Funeral	1 Never Married 2 Married	12. Was Decedent Armed Forces: 1 ☐ Yes 2 ☐ If Yes, Give	No No		Was Dece If Yes, spe 1 ☐ Yes			gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	•	14. Race - Ame Black, Whit		
Ö	hour tural	ed b	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Edu	Year or Dates:	Viet	1					-	101 16			
Maryland 21215-0036	nin 72 In *na Medic	Completed	(Specify only highest grade	Completed)  College (1-4or	E.\	(Give	edent's Usu e kind of wo DO NOT u	rk done di	uring most	of working		16b. K	ind of Business/	Industry	
2	filed with Hygiene other the	Com	12	College (1-40)	J+)		Carpe	enter				Но	me Impr	ovement	S
nd	be file	Be	17. Father's Name (First, Middle, Last)				_				First, Middle,	Maiden	Sumame)		
<u> </u>	should be ind Mental marked o	ဥ	Albert Owens  19a. Informant's Name/Relationship (Ty	no Drintl		405-14-15					Finn∈				
	od 2 s Ith an 27 is r		Jeannie L. Owens/D	-			ng Address 24 Fl						nr Town, State, 2 MD 2122		
Je,	of Heal		20a. Method of Disposition		20b. F	Place of Disperentery, cre	osition (Na	ne of			-		ocation - City or		
Ē	Page		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	- 1	cro Cr			,	2004	-y 15,	Bal	timore,	MD	
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: if Item 27 is any injury or other tre		21. Signature of Filheral Service License	76 71	~	E	2. Name ar	co &	Sons	. P.A	. Sev	erna	a Park I	Juneral	Home
<b>S</b> <sub>2</sub> (1)	Crate be executed  /Medical Examiner sthe burial-transit	dical Examiner	23a. Page. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequa consequa	uence of):	and A	icauoi	Intax	rication of the second of the	n <del>(Lone</del>			Approximating interval Bet Onset and	ween
.O. Box 6	ath certif attending or use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal	death 3	Ectopic pr					2	23d. Date of deli Month		Year
rds, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	tributing to death b	ut not rest	ulting in the u	nderlying c	ause giver	in Part I.				se contribute to □No 3□Pro		
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		o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	ospital:	-, 300	FD/0		Others			heck only on				
		$\vdash$	27. Manner of Death	1 ☐ Inpatie	ry	ER/Outpatier 28b. Time of		8c. Injury a Work?	4 LINUIS		5 🗌 Reside		Other (Spec	ify)	
0	Attending I death. ctor: After y the funer	atlo	1 Natural 5 Pending investigation	four (Month, Day 1/16/04	y y ear)	found 10:35	М	Work? 1 ☐ Ye	s 2.1≱No	o	unknown	1			
DIVISION	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funerel.	Certification:	3 Suicide & Could not be determined	28e. Place of Inju- building, etc found at	c. (Specify	")	eet, factory	, office			City or Town	, State)			ber,
	lospite 1 hours 1 unere aly fille	edical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best	of my know	wledge death	occurred	at the time	, date and	nlace and	due to the or	1100/01	gewater,M and manner as	stated	
	thin 2, the F the F mplets	Medi	one) 29b. Signature and title of certifier	and manner sta	ited.	.o. and or m				000uir <b>90</b> 8					)
)	ž M Ž		Zalu'lle	al Al	2		290	O.C.			1		e signed <i>(Month,</i> ary 18,		
			30. Name and address of person who cor		eath (Item	23а) (Туре,			~ .						
	Sta	- A	31. Date filed (Month, Day, Year)	32. Reastra	ar's Signat	ture 🚣	111	renn	stre	et, E	saltimo	ore,	Maryla	nd 2120	)1
49.71	Registra	ar	JAM 9 1 2	1114	Sugar .		Charles S.								

				For State Registrar	State of M	1arylar	-			lealth a Death			Reg. No.	2001	031	57
		Physicia		Decedent's Name (First, Middle, La	Robert	Eugen	ie Pahe	1				2. Date of De Month January	Day	Yeer	3. Time of De	eath P
		/Medic Examin		4a. Facility Name (If not institution, given St. Mary's Hospi		r)		Leo	nardt		Death		4c. (	County of Deet Mary 's	h 5	
		Funeral Director		186-32-4293	Sex 7. A 1 ☑ M 2 ☐ F	ige (In yrs.	last birthday) Yrs.	Months	er 1 Year Days	If Under 2 Hours	Min.	B. Date of Bir (Month, Da July 5,			hplace <i>(State or F</i> u <i>ntry)</i> sylvania	Foreign
		aryland ehow	Ļ	Usual Residence of Decedent  10a. State  10b. County	•	10c. C	ity, Town or Lo								10d. Inside City	
		th the March or 28a-f	Funeral Director	Maryland St. Ma  10e. Street and Number	ry's		Mecha		ip Code				10g. Citiz	en of What Co		
		th will	a D	42041 Woodland R	oad					20659			U	SA		
	36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or litems 23s or 28s-f show other traumatic avent, the Wedical Examinal must be nutilised at	by	11. Marital Status  1 □ Never Mamed 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Deceder Armed Forces 1 Tes 2 If Yes 2 If Yes, Give Year or Dates	s? <b>X</b> No	J.S. 13.		edent of Hecify Cuba 2X No	lispanic Orig an, Mexican, Specify:	in? (Spec Puerto P	ify Yes or No ican, etc.)		4. Race - Ame Black, White Specify: Wh	e, etc.	
	21215-0036	hin 72 hou e. en "nature Medical E	Be Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4o	r 5+)		kind of w DO NOT	rork done use retired	ation during most d)	of workin	g		d of Business/		
	21	e filed withing Hygiene. other ther	Соп	12			1	rint	er					licatio	n	
	Maryland	ntal H ed oth		17. Father's Name (First, Middle, Last Edward Juni						Marga		(First, Middle,	, Majden S	sumame)		
	Z	2 should be I and Mental I Is marked o	은	19a. Informant's Name/Relationship			19b. Maili	ing Addre	ss (Street				er, City or	Town, State, Z	(ip Code)	
	Ž	and 2 saith a n 27 la		Jennifer Leigh Crager	/Daughter		_			ne, Leo	- 100	own, Mar				
	Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [	Removal from Stat	e	Place of Dispo cemetery, cre	matory of	other plac	, pa	nuary	24,		cation - City or		
	ij	nit. Paratmer ortant injury		* 4 □ Donation * 5 □ Other (Special Signature of Funeral Service Lice		Met		2. Name	and Addre	ss of Facility				ndria, Vi	rginia	
	Ba	Depa Impo Eny is		1 file de	mem_		1	Mattir P.O. F	gley-(	Gardine:	r Fune	eral Hom Vn, Mary	e, P.A land 2	A. 20650		
	1	Physi <b>cia</b> n	10.5	23a. Part // Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	polications that cause on each	ed the dea line.	th. Do not en	ter the m	ode of dyin	ng, such as o	cardiac or	respiratory a	rrest,	Carlo	Approximate Interval Betwee Onset and Dec	en eath
i		/Medical Examiner		resulting in death)	Du a to (or a	as a conse	quence of):									
Patter		uted I	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conse	quence of):								-	
9)	8760,	ate be executed hysician and the burial-transit	ical	that initiated events resulting in death) Last	Due to (or a	as a conse	quence of):									
Eugen	O. Box 68	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Fet at time of	al death 3[	⊒Ectopic ⊒ Other (	pregnancy specify)	′			2	3d. Date of del Month	very Day Yea	ar
Robert	ds, P.	uires that the signed by		Part II. Dther significant conditions	contributing to death	but not re	sulting in the u	underlying	cause giv	en in Part I.				_	the cause of dea	
S	Records,	The law requir ate has been si page 2 should	Completed									24a. Was auto perfo	psy prmed?	24b. Were au prior to death?	topsy findings ava completion of cause	ailable use of
	ita	icien: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only				
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	ono	ding P. h. After t	tion:	27. Manner of Death 1 ØNatural 5 □ Pending 2 □ Accident investigation	28a. Date of In (Month, L	njury Da <i>y</i> Ye <i>ar)</i>	28b. Time o	of M	28c. Injur Wor 1 🗆	yat k? Yes 2 □ N		3d. Describe	how injury ~	occurred		
	Division	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not 4 Homicide determined	28e. Place of I	injury - At i etc. (Spec	home, farm, st	reet, facto	ory, office		2	Bf. Location ( City or To	Street and wn, State)	Number or Ru	ral Route Numbe	∋r',
		To the Hospit within 24 hour To the Funers completely fills	edical (		hysician: To the bearing of the basis and manner	of examin										
		To the within To the comp	Me	29b. Signature and title of certifier	J_	_		2	9c. Licens	e number			29d. Date	signed (Monti	n, Day, Year)	
	(%	O.O		MIN	James	)	22a) (T		0145	-85			1-	- 33-6	oy	
		15		30. Name and address of person who Dr. William Boyd, 2					dtown	, Maryl	and 20	0650				
		Sta Registi		31. Date filed (Month, Day Year)	2004 32. Red	strar's Sign	nature	done	(k)							

			For State Registrar	State of Ma		epartment C <i>ertificate</i>			ınd M		giene Reg. No. 2	004	03158
			1. Decedent's Name (First, Middle, La	st)						2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medic		Lucy Elizab		ogue					January			8:30 am
	Examin		4a. Facility Name (If not institution, gi			7.		Location o	f Death			nty of Death	
			36850 Bushwood				ushw	ood If Under 2	DA Hec	O Data of Birds		. Mary	
	Funeral Director		212-54-6747	Sex 7. Ag 1 □ M 2 <b>X</b> □ F	e (In yrs. last birth	Months	Days	Hours	Min.	8. Date of Birth (Month, Day May 20,	, Year) , 1911	Cou	place (State or Foreign ntry) rland
	pur M		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Aaryla F sho	5	Maryland St. Mar	v¹s	Bush	wood							1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number	<i>y</i>		10f. Zip	Code				10g. Citizen	of What Cou	ntry?
	3a or		36850 Bushwood	Wharf Rd.			206	18			USA		
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Deced	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. F	lace - Amer lack, White	
21215-0036	filed within 72 hours after death with the Maryland Hygiene uther than "natural", or flems 23a or 28e-f show uther than "natural", or flems 23a or 28e-f show but, the Madical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 If Yes, Give Year or Dates:		1 ☐ Yes						city: Wh:	ite
9	2 hot	Completed	15. Decedent's l	ducation		Decedent's Usua (Give kind of wo	rk done d	turina mosi	t of work	ina	16b. Kind of	Business/l	ndustry
215	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT us	se retired	)			C1 - ±1	C	l trans
	ed wi	Sol	12		S	ales Cl	erĸ	19 Mothe	rte Name	e (First, Middle,		ning S	core
nd	be file of oth	Be	17. Father's Name (First, Middle, Las							Chomas F		ianio)	
<u>\Z</u>	should nd Men marke umatic	은	John Hurry I		19h	Mailing Address	/Street					wn. State. Zi	in Code)
Maryland	id 2 sh lth and 27 is m traum		19a. Informant's Name/Relationship Ann Holt Pogue	- Daughter		850 Bus							20618
ē,	thealth tem 27 other t		20a. Method of Disposition		20b. Place of	Disposition (Nar	ne of other plac	e)	Jani	Date uary	20c. Location	on - City or 1	own, State
ê	Pages nent of t ant: If its ury or o		1 🛣 Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spec			ints Cem				,	Avenue	, Mar	land
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any once.		21. Signature of Funeral Service Lic	ensee Hand	L.	22. Name ar Matt	ingl	s of Facilities	irdi:	ner Fune nardtown	eral Ho	ome, I 20650	A.
	Su A		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each	d the death Do n	ot enter the mod	e of dyin	g, such as	cardiac				Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Re-z Due to (or as	s a consequence of		r	nlar	· /	gniff	enc		
1964	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence o								
3760,	ate be execu hysician and he burial-trai	cal		d									
.O. Box 68	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		e of pregnancy 2 Fetal death at time of death	3 □Ectopic p 5 □ Other (s <sub>i</sub>		,			23d.	Date of deli Month	very Day Year
<u>α</u>	es be	ρ	Part II. Other significant conditions	contributing to death	but not resulting in	the underlying	cause giv	en in Part I	l.	23e. Did t			the cause of death?
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al F						_				1 Yes	20 No	1 U Yes	2 No.
Vital	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	tient 2 ER/Ou	testion: all a	OA Oth	lor.	e of Dea ursing He	th (Check only o	dence 6 🗆	Other /Sno	rufu)
To	Phys r this ral dii	on: To	1 Yes 2 No 27. Manner of a 1 Natural 5 Pending	28a. Date of In (Month, D		ime of	28c. Injui Woi	y at		28d. Describe			ary)
Division	at in a	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	be 28e. Place of li	njury - At home, fa atc. (Specify)	rm, street, factor		Yes 2	]No	28f. Location ( City or To	Street and Ni wn, State)	umber or Ru	ral Route Number,
	To the Hospital or Atta within 24 hours after de To tha Funaral Directo completely filled in by th	ledical Ce	29a. Certifier Certifying (Check only 2 Medical Ex	Physician: To the bes	of examination an	o, death occurred d/or investigation	d at the til	me, date a	nd place ath occu	, and due to the rred at the time,	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s)
	To the within 2.	Med	one)  29b. Signature and title of certifier	and manner s	stateu.			e number			29d. Date si	gned (Monti	y Day, Year)
	7 × 3		A	1			01	99	17		1/	19/0	24
	20		30. Name and address of person w	no completed cause of	death (Item 23a)						/	1	•
(	213				od Shoppi		er,	Calii	forn	ia, MD 2	20619		
	S	tate	31. Date filed (Month, Day Year)		ar's Signature	k 7	مد				• • • •		
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		-	For State Registrar	State	e of Ma	aryland		artment of I				giene Reg. No.	200	4 03	3159
		75	Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	ith Day	Year		of Death
	Physici		Violet Louise 1	umphre	У						January		2004		9 p.M.
	/Medio Examin		4a. Facility Name (If not institution,					4b. City, Town,	or Location of	of Death		4c. (	County of De	ath	-
836			39628 Lady Bal	imore	Avenu	ie			nardt				Saint 1	Mary's	
	Funeral		5. Social Security Number	3. Sex 1 □ M 2 🔀		e (In yrs. la	ast birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day	h /. Ye <i>ar)</i>	9. Bi	rthpiace (State Country)	e or Foreign
24	Director		577-03-1655	1 L M 2123		91	Yrs.				7/31/19	912	Ma	ryland	
	pur *		Usual Residence of Decedent  10a, State 10b, County			10c. City	, Town or Lo	cation					<del></del> -	10d. Inside	City Limits
	lanyla sho	ō		v 1		T .	14							1 🗆 Ye	es 2∑No
	28a-1	Director	Maryland Saint  10e. Street and Number	Mary's		Le	onardt	10f, Zip Code				10g. Citiz	en of What C	Country?	
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	n 72 hours after death with the Maryland "natural", or Itema 23a or 28a-f show adical Examinet roust be natified at	Funeral	11. Marital Status	12. Was	Decedent		S. 13. 1	Was Decedent of f Yes, specify Cub			cify Yes or No-		4. Race - Arr	erican Indian,	
<b>10</b>	r Her	Fun	1 Never Married 2 Marrie	d 1 □ \	d Forces?	No					Hican, etc.)		Black, Wh	ite, etc.	
036	urs a	þ	3  Widowed 4 □ Divorced	If Yes Year	s, Give or Dates:			1 ☐ Yes 2X No	Specify:	'			Specity: W	hite	
5-0036	72 ho	Completed	15. Decedent's (Specify only highest	Education	ited)		16a. Dece	dent's Usual Dccu kind of work done	pation during mos	t of worki	ng	16b. Kin	d of Busines	s/Industry	
21	e. en "r	nple	Elementary/Secondary (0-12)	T	ige (1-4or 5	i+)	life.	DO NOT use retire	ed)						
21	fited within Hygiene. other then "	Col	10th				Hor	nemaker	T				n Home		
pu	be file	Be	17. Father's Name (First, Middle, L	ast)							(First, Middle,		Sumame)		
yla	2 should be fited within and Mental Hygiene. Is marked other than aumatic avent, the Ma	မ	Jackson B. Abe								Connell		<b>*</b> C1-1-	7(- O- d-)	
Maryland	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If item 27 Is marked other than "nature or other traumatic avent, the Medical		19a. Informant's Name/Relationsh					ng Address (Stree							20650
	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra ong.e.		Frank N. Pump  20a. Method of Disposition	nrey /	Son	20b. P	lace of Dispo	628 Lady			Ave.,			or Town, Stete	20030
Baltimore,	ges it of the it it is		1 😾 Burial 2 ☐ Cremation		from State	Cé	emetery, crei	matory or other pla		1/1					
ţ	nit. Pagartmen ortant: injury		'4 Donation 5 Other (Sp	//		Re		ction Cer 2. Name and Addr						larylan	
Bal	permit. Page Department Important: If any injury of		21. Signatura Euneral Solver	N	7	, ,		22955 H							
22			Edward N. Brins 23a. Pert1. Enter the disease, or	field,	that caused	MOO(							cowir,	Approxim	nate
K.			shock, or heart failure. List of Immediate Cause (Final	nly one cause	on each li	ne.	1	0 .	V					Onset an	nd Death
	Physician /Medical		disease or condition resulting in death)	a	e to (or	-		art fa	1100 0					well	.5
	Examiner			0.0	Hr. 7	Scol	יוס ביוופ	COTON	was	Leny	diseas	0		year	5
		اة	Sequentially list conditions, if any, leading to immediate	b. Du	e to (or as	a consequ	uence of):	00.01	0	0	0 . 400.			1	
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events											kii	
o,	be executician and burial-tran		resulting in death) Last	Du	e to (or as	a consequ	uence of):								
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9	certificate Iding phys	led	IF FEMALE:						-						
Box	eath certifica attending ph for use as th	an/l	23b. Was decedent pregnant	101	s, outcome Live birth	2 Fetal	death 3	⊒Ectopic pregnan	су			2	3d. Date of d Month	elivery Day	Year
	e death he atter	sici	in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown		Pregnant a Unknown	t time of de	eath 5	Other (specify)						,	
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orc	v requires been sign should be	Completed	1-6-1	A							21.116		0.45	t findin	
ec	± 00 0.	npie	al Zheiner's	drsexi							24a. Was autop		prior to death	autopsy finding completion o	of cause of
E H	cate has	ပိ									1 ☐ Yes	2 <b>N</b> O		s 2 No	
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isi	l or Attending after death. Director: After in by the fune	icat	3 Suicide 6 □Could r		Place of In	iury - At ho	ome, farm, st	reet, factory, office			28f. Location (S			Rural Route N	lumber,
Οį	spitel or A ours after nerel Direc filled in by	Certification:	4 Homicide determi	ned	building, e	ic." (Specif)	y)				City or Tov	vn, State)			
	Hospitel 24 hours a Funerel tely filled		29a. Certifier 1 Certifyin	Physician: 1	To the best	of my kno	wiedge, deal	th occurred at the	time, date a	nd place,	and due to the	cause(s)	and manner	as stated.	
		edicai	(Check only 2 Medical I		the basis of I manner st		tion and/or in	vestigation, in my	opinion, de	ath occurr	ed at the time,	date and	place, and d	ue to the caus	e(s)
	To the Within 2 To the comple	Me	29b. Signature and title of certifier					29c. Licer	nse number					nth, Dey, Year	r)
			<b>&gt; X</b> O	2	1	-		Dr	1250	17		1-	13-	64	
19	25		30. Name and address of person												
~								Center, F	oint	Look	out Rd.	, Lec	nardt	own, MI	20650
	St	ate	31. Date filed (Month, Day, Year)	1 0 00	32. Regist	s Signa	iture	Annalla	P						

			For State Registrar		State o	of Marylai	nd / Depa		of H	ealth a				004	03160
			1. Decedent's Name (First	Middle, Las	t)							2. Date of Dea			3. Time of Death
	Physici /Medio		William	, Pri	cl							Month 9 am	Day 18	2004	1620 M
	Examin		4a. Facility Name (If not in	stitution, give	street and nu	ımber)		4b. City, 7	Town, or	Location o	f Death	0	4c. Co	unty of Deal	
			Darchist	NL	m. 1	Hospi	tal	CO	mi	- 0	ze		al	erchi	etir
	Funeral		5. Social Security Number	6. Se	ex 27 M 2 □ F	7. Age (In yrs.	"	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birtl _(Month, Day	Year)	9. Birt	hplace (State or Foreign ountry)
	Director		224-50-6725 Usual Residence of Deced		<b>4</b> C .	6:	2 Yrs.					Feb. 2,	1941	lews.	ressee
	tand ow			County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
	Mary f sh	ğ.	Maryland I	orche	ater		Cambrid	laa							1.₽Yes 2 □ No
	1 the	rec	10e. Street and Number	orche	SCCI		Oambiic	10f. Zip	Code				10g. Citizer	n of What Co	ountry?
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	death	Funeral Directo	11. Marital Status		12. Was Dec	edent Ever in t	J.S. 13.				in? (Spe	cify Yes or No- Rican, etc.)		Race - Ame	
ဖွ	after or Ite	Ē	1 Never Married 2		Armed Fo 1 ☐ Yes If Yes, Gi	2 <b>7</b> No		n res,speci 1 □ Yes 2		Specify:	, Pueno I	Hican, etc.)		Black, White	e, etc.
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	filed within 72 hours after death with the Maryland Hygiene. ther than natural, or Items 23e or 28e-f show ant, the Madical Examinar must be notified a	ပ္သ	12 17. Father's Name (First, I	fiddle, Last)			Equi	ltment				(First, Middle,		struct	lon
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Maryland	should ind Men i marke umatic	-	19a. Informant's Name/Re				19b. Mailir	na Address	(Street a			a Mary I Route Numbe			7in Code)
Ĕ	17 th a 17 th		Charles P	ice/	Brothe	r						imore,			
Baltimore,	ges 1 and of Heal		20a. Method of Disposition			20b.	Place of Dispo cemetery, crer							ion - City or	
E	Pages nent of int: If it		1 🕽 Burial 2 □ Cren 1 □ Donation 5 □ O	ation 3 ∐ her (Specify	Removal from	State	ethel (			1	01/24	4/2004	Camb	ridos	Maryland
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			23a. Par 1. Enter the dise shock, or heart failur	ase, or comp	lications that one cause on e	caused the dea	th. Do not ent	er the mode	of dying	, such as c	ardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		· A	D5								}	Onset and Death
	/Medical Examiner		resulting in death)		Due to	(or as a consec	quence of):				,		,		
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	ed isit	Jine	Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	°₹	Due to	(or as a consec	quence of):								
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	1	c. Due to	(or as a consec	quence of):								
8760,	cate be executed physician and the burial-transit	icai		- (											
687	Attending Physician: The law requires that the death certificate be executed to death. T death. stor: Atter this certificate has been signed by the attending physician and stors. Atter this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	edic		-	O										
ŏ	nding use a	N/	IF FEMALE: 23b. Was decedent pregn	ant		tcome of pregn		_					23d.	Date of deli	verv
m ·	death e atte	icia	in the past 12 months 1 ☐ Yes 2 ☐ No		4 ☐ Pregr	oirth 2 ☐ Feta nant at time of c		]Ectopic pre ] Other (s <i>pe</i>						Month	Day Year
P.O. Box 6	at the by th tache	Physician/Med	9 ☐ Unknown		9□ Unkn	own									
ŝ	es that the death certific igned by the attending p be detached for use as	by	Part II. Other significant of	onditions co	entributing to d	eath but not res	sulting in the u	nderlying car	use give	n in Part I.		23e. Did tol	oacco use	contribute to	the cause of death?
D.C	w require	ted				<del></del>						1 □ Ye	s 270 N	o 3⊟Pro	bably 4 Unknown
Records,	elaw n hasbe	ple										24a. Was a autops		4b. Were au	topsy findings available ompletion of cause of
<u> </u>	The page	Completed										perform		death?	2 □ No
Division of Vital	ician: Sertific ector,	Be	25. Was case referred to reaminer?	-	Hospital:						of Death	(Check only on	ө)		
<del>o</del>	Phys this al dir	٦.	1 Yes 2 No 27. Manner of Death		1 64		ER/Outpatien			4 🗀 Nurs		e 5 Reside			ify)
G	ding h. After funer	tion	1 Natural 5 □	Pending nvestigation	(Mon	of Injury th, Day Year)	28b. Time of Injury	M 28	C. Injury	at ? es 2.∐N		Bd. Describe ho	w injury oc	curred	
<u>s</u>	Attendi death. ctor: A y the fu	fica	3 ☐ Suicide 6 ☐	Could not be	28e. Place	of Injury - At h	ome farm str			03 2 11		Rf Location /St	reet and M	umber or Pu	ral Route Number,
É	after after Dire	Certification:	4  Homicide	Jetermined	buildi	ing, etc. (Specia	fy)	,,	011100		-	City or Towr	, State)	377.007 07 710	ar rioute ryamber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 🗆 C	rtifying Phy	sicien: To the	best of my kno	owledge, death	occurred at	t the time	e, date and	place, ar	nd due to the ca	use(s) and	I manner as	stated.
	he Ho in 24 he Fu pletel	Medical	(Check only 2 M one)	odical Exam	iner: On the b	asis of examina ner stated.	ation and/or inv	estigation, i	n my opi	nion, death	occurre	d at the time, da	ate and pla	ce, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of	entifier				29c.	License	number		2:	d. Date sig	ned (Month	, Day, Year)
			1 april	NAM				H	00	599	773		1/	18/0	4 435 Pm
			30. Name and address of	1	6 /		. 1			Me		7	141		
	CAN		31. Date filed (Month, Day	MbC	32 8	enistar's Sign	Anby (	ref		111		of ,	4/	7	
	Sta Registr		(	AN 2	2004	negistar's Signa	1.	Speed							

Amended Item 17 per F.D. 01/16/2004 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** NORA LEE PERRON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BROOKFIELD MANOR **KEYMAR** CARROLL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F 578-22-1330 Yrs. 25/1919 Director 84 VIRGÍNIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23e or 28a-1 show the Medical Evants or must be notified at 1 Yes 2 No MD. CARROLL WESTMINSTER Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1250 PLEASANT VALLEY RD. 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race · American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: WHITE þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SALES CLERK RETAIL STORE 12 t of Health and Mental Hyg If Item 27 Ia marked othe or othar treumatic event, 17. Father's Name (First, Middle, Last) JAMES BENJAMIN DURHAM 18. Mother's Name (First, Middle, Maiden Sumame) Be BRINKLEY MARY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 19a. Informant's Name/Relationship (Type, Print) 1250 PLEASANT VALLEY RD., WESTMINSTER, MD. LINDA LANGDON - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. PLEASANT VALLEY, MD 1/17/04 PIPE CREEK CEM. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityFLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 49 curs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 28 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) - LIVING Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Nother (Specify) After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Alatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, or Attending Physician: within 24 hours after death.

To the Funeral Director: Af Hospitel

within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

ARICOTE MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 1 6 2004

WJZ

29c. License number

000090

29d. Date signed (Month, Day, Year)

21791

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	State of Maryland / Department of Health and Mental Hygiene 2004	091
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V			1 - For State Registrar Amend Item#5pe	erFHG828 2/6/04 E	v Ce	rtificate of	Death		teg. No.	14	03162
I	Dhysisi		1. Decedent's Name (First, Middle, Last	")				2. Date of Dea Month	th Day Y	'ear	3. Time of Death
	Physicia /Medic		Christopher	Michael		Pugh		Januar			1819 P™
	Examin	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of Prince		~~ala
_			9700 Block Mayapp  5. Social Security Number 6. Se		last hirthday	Clinto		8 Date of Birth			
ě	Funeral Director	-		OM 2□F 22	Yrs.	Months Days		8. Date of Birth (Month, Day April 1			ece (State or Foreign ry) ington DC
	land ow		10a. State 10b. County	10c. Cit	y, Town or L	ocation				10	d. Inside City Limits
	Mary a-f sh	tor	Maryland Prince Ge	eorge's	Clint	con					1 ☐ Yes 2 No
	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23e or 28e-f show imalic event, the Wedical Evaining ripulation hydified at	i Director	10e. Street and Number 9402 Pineview La	ane		10f. Zip Code 207	35	1	10g. Citizen of Wh		ry?
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of I	Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race -	America White, e	
020	ours after ai', or ite Evamme	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2½ No		riioari, etc.)	Specify:	vviile, e	White
ה ה	72 ho	eted	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occu	during most of work	ing	16b. Kind of Busin	ness/Ind	ustry
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7	filed withi Hygiene. other than		12th 17. Father's Name (First, Middle, Last)		1101.00	ICHILD ICH	18. Mother's Name		US Dept.		Athy
מום	0 - 0 5	o Be	Thomas L. Pugh					Line N.			
<u> </u>	should be nd Mental marked o	င္	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mail	ng Address (Street	and Number or Rura			ate, Zip i	Code)
Z	nd 2 alth al 27 is r trau		Jacqueline N. Pug	jh (Mother)	1		iew Lane				
ĬĠ,	item item		20a. Method of Disposition	20b. P		osition (Name of matory or other pla			20c. Location - Ci		
	Page nent c int: If		1 ØBurial 2 ☐ Cremation 3 ☐ I 14 ☐ Donation 5 ☐ Other (Specify,	Telliovariiolii State		tion Cem			Clinton,	Mar	vland
Dallillo	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic es		21. Signature of Funeral Service Licens			2. Name and Addre			ral Home		
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
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O. DOX	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetel 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month		y Day Year
Ĺ	that	by Pr	Part II. Other significant conditions co	ntributing to death but not resi	utting in the t	inderlying cause giv	ven in Part I.	23e. Did tot	bacco use contribu	ite to the	cause of death?
SDIOS	quires in sign							1 □ Y∈	es 2 X No 3 (	] Proba	bly 4 □Unknown
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Ĕ	The I	mo:						autops perform	ned? dea	th?	pletion of cause of !□ No
N I G	itan: artifica ctor. p	Bec	25. Was case referred to medical examiner?				26. Place of Death				·
5	hysic his ce al dire	၉	1 X Yes 2 □ No		ER/Outpatie	III 3 DOA	The state of the s			Specify)	At scene
	ling P	Certification:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe ho	ow injury occurred		^ -1
202	death ctor: , the	icat	2 Accident investigation 3 Sujicide 6 Could not be	28e. Place of Injury - At ho	me farm st			28f Location (St	reet and Number	or Bural	Route Number
2	after Dire	erti	4 Momicide determined	building, etc. (Specify	PA	ik_	c	City or Town	n, State)	10	CT
	spits hours ineral y filler		29a. Certifier 1 ☐ Certifying Phy	sician: To the best of my kno	wledge, dea	h occurred at the ti	me, date and place,	and due to the ca	ause(s) and mann	er as sta	ted.
	he Ho in 24 he Fu pletel	edical	one	iner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my	pinion, death occurr	ed at the time, da	ate and place, and	due to t	he cause(s)
	with To t	Σ	29b. Signature and title of certifier	440		29c. Licens			9d. Date signed (A		
			- Clar	NY		0.0	.M.E.	J	January 2	0, 2	2004
1	B 10		30. Name and address of person who co	EMO	111	Penn Str	eet, Balt	imore, M	Maryland	2120	01
100	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 3 2	32. Rigistrar's Signa	dura /	berte					

DHMH 17 Rev 1/2001

			AMEND#18 1/26/0\$ta  State AACO HEALTH DEPT Registrar		epartment of H Certificate of L			iene <sub>19. No.</sub> 20	04	03163
- 36,46	Dhysiais		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day	Year	3. Time of Death
	Physicia /Medic		ROBERT HENRY HORACE P				JANUARY			6:35 A M
	Examin	er	4a. Facility Name (If not institution, give street a CROFTON CONVALESCENT		4b. City, Town, or CROFTON	Location of Death		4c. County	of Death	NDET
	man Albertage .	H	5. Social Security Number 6. Sex	7. Age (In yrs. last birth		If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign
	Funeral Director		084-05-8429 <sup>1⊠M 2</sup>		rs. Months Days	Hours Min.	(Month, Day, JULY 18	, 1910	PENN	SYLVANIA
R.	Ö		Usual Residence of Decedent						1	0d. Inside City Limits
-	arylar ehow	-	10a. State 10b. County	10c. City, Town					1	1 X Yes 2 ☐ No
	28a-f	ecto	DELAWARE   NEW CASTLE	WILMIN	10f. Zip Code		1	0g. Citizen of V	What Coun	itry?
	with the or	0	1706 NORTH BANCROFT P	ΔΡΚΜΔΥ	19806			U. S.A		,
	sr death with the Maryland tems 23a or 28a-f show or mist be rediffed at	Funeral Directo	11 Marital Status 12. Wa	as Decedent Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cuba		ocify Yes or No-	14. Rac	e - Americ	
	after or Ite	þ	1 Never Married 2 Married 1 (If )	med Forces? ]Yes 2[X]No ∕es, Give ar or Dates:	1 ☐ Yes 2 ∏ No	Specify:	nican, etc.)	Specify	ck, White, WH	ITE
215-0036	72 hours natural', Ilcal Exa	Completed	15. Decedent's Education (Specify only highest grade com	oleted)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation Juring most of works	ing	16b. Kind of B	usiness/Ind	dustry
7	within 72 ene. than nai	nple	Elementary/Secondary (0-12) Co	llege (1-4or 5+)		)		CHEMIC		
N	filed w Hygier sther ti		12 17. Father's Name (First, Middle, Last)	10   CH	IEMIST	18. Mother's Name	(First, Middle, I	INDUST Maiden Suman		
Maryland	e d la be	) Be	ROBERT HENRY HORACE P	IERCE			A PEARL			
<u> </u>	2 should be and Menta Is marked eumatic ev	ဥ	19a. Informant's Name/Relationship (Type, Pr	int) 19b.	Mailing Address (Street a	and Number or Rura	al Route Number	, City or Town,	State, Zip	Code)
	7.5 € d		DOROTHY H. PIERCE/DAU	GHTER 17	88 REGENTS	PARK RD.,	CROFTO	N, MD	21114	+
ğ	Ø O N		20a. Method of Disposition 1    M Burial 2 □ Cremation 3 □ Remov	20b. Place of cemeter)	Disposition (Name of r, crematory or other plac	θ)		20c. Location -		
Ĕ	Pages ment of ent: If it ury or o		*4 □Donation 5 □ Other (Specify)	WOODLA	WN CEMETERY	,		BRONX,		
Baltimore,	permit. Page Department of Importent: If eny injury or		21. Signature of Funeral Service Licensee		22. Name and Address 16000 ANNA				20715	
	40 to 94		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final	s that caused the death. Do not see on each line.						Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition	Due to (or as a consequence of	. Card	1901	113-60	2/36		Jeans,
7	Examiner			Cardion	myopa	thy				years
	₽ #	ner	cause. Enter Underlying	Due to (or as a consequence of	of):					4
	ecute and trans	Examin	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a consequence of	of)-				-	
8760,	cate be executed physician and the burial-transit	a E		500 (5) (5) 25 2 5511554551155	,.				- 3	
387	physics the	edical	d	- No. 17 (1990)						
×	es that the death certificing of the attending of the detached for use as	Physician/Me		yes, outcome of pregnancy	a Circumia and an annual			23d. Da	te of delive	эгу
.O. Box	death e atte	lcia	in the past 12 months?	Live birth 2 Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Mo	onth	Day Year
P.0	at the by th	hys	9 Li Unknown				00 0144			he cause of death?
s,	es tha igned be de	þ	Part II. Other significant conditions contribut	ing to death but not resulting in	the underlying cause given	en in Part I.	=====================================	es 2 No		pably 4 Unknown
ord	w require been si should I	eted	Men 1000 (0	y jewn or						-
3ec	25 8	Completed					24a. Was a autop: perfor	sy med <b>2</b>	prior to co death?	ppsy findings available mpletion of cause of
a	n: Th ficate r. pag		25. Was case referred to medical			26. Place of Deat			1 🗌 Yes	2 No
₹	Physicien: rthis certific ral director,	o Be	examiner?  1 Yes 2 No Hospit	al: 1   Inpatient 2   ER/Ou	tpatient 3 DOA Oth		me 5 Resid		ner (Specif	v)
of	g Phy er this eral d	n: To	27. Manner of D ath 28	a. Date of Injury 28b. T	ime of 28c. Injur	y at	28d. Describe h			
ion	Attending r death. sctor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Yes 2 □No				
Division of Vital Records,	after de Directo	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28	<ul> <li>Place of Injury - At home, fall building, etc. (Specify)</li> </ul>	rm, street, factory, office		28f. Location (S City of Tow		ber or Rum	al Route Number,
	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	ledical C	(Check only 2 Medical Exeminer: (	a: To the best of my knowledge On the basis of examination and and manner stated.						
	omple	Mec	29b. Signalure and title of certifier		29c. Licens		P 2	29d. Date signe	d (Month,	Day, Year)
	->-0		Y Kakitho	notal	11) D	2010	8	1/=	23/	04
			30. Name and address of person who comple							
			Rakesh Arora, MD	14300 Gallar	nt Fox Lane	Suite 222	2, Bowie	, Maryl	and	20715
	St Regist	ate	31. Date filed (Month, Day, Year)  JAN 2 3 2004	32. Registrar's Signature	South 5					

			1- For State Registrar	·	artment of Health and rtificate of Death		iene	04 03161
	Physic		1. Decedent's Name (First, Middle, Last)	erry		2. Date of Death Month	Day	Yeer C618 M
	/Medi Exami		4a. Facility Name (If not institution, give street and it	omter)	4b. City, Town, or Location of Deat	Jan	4c. County of	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF	7. Age (In yrs. last birthday, Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, October 1	Year)	Birthplace (State or Foreign Country)     Maryland
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicomico	10c. City, Town or L				10d. tnside City Limits 1X Yes 2 □ No
	with the	Dire	10e. Street and Number 351 Deers Head Hospita	l pa	10f. Zip Code	10	g. Citizen of Wh	nat Country?
920	72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show odical Examiner must be notified at	by Funeral Directo	11. Marital Status 12. Was De Armed	cedent Ever in U.S. 13. Forces? 13. 2 X No	21802 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		- American Indian, White, etc. White
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College 7 College	(Give life.	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)  NSTRESS	king	6b. Kind of Busi	iness/Industry Factory
	ould be filed Mental Hygi arkad other atic event, II	Be	17. Father's Name (First, Middle, Last)  Marion Trader Sr.			ne (First, Middle, M	laiden Sumame)	
Maryland	and 2 should be filed withir ealth and Mental Hygiene. m 27 is marked other than her traumatic event, the Manaric event eve	2	19a. Informant's Name/Relationship (Type, Print) Marion Trader Jr./brot	her PO I	Mattie ng Address (Street and Number or Ru Box 534, Hebron, N	ral Route Number.		tate, Zip Code)
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr ance.		20a. Method of Disposition  135 Burial 2 Cremation 3 Removal from  4 Donation 5 Other (Specify)	20b. Place of Dispo	esition (Name of matory or other place)	811	0c. Location - Ci Siloam,	ity or Town, State
Balt	permit. Pag Department Important: any injury o		23a. Part 1. Enter the disease, or complications that	NO CHOP	Name and Address of Facility Holloway Funeral H Holl Snow Hill Rd.,	Salisbu	ry, MD 2	l Association 21804
8760,	Physician /Medical Examiner be executed by sician and physician and the prujel-transit	ical Examiner	shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to Cause (Disease or injury that initiated events resulting in death) Last	of or as a sheequence of):  Aveles of (or as a consequence of):  Ayker Husio (for as a consequence of):	nal disease lellihus hype ni	2		Interval Between Onset and Death  2 yrs  more than 2yr  man than 2yrs
O. Box 6	The law requires that the death certificate be executed te has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of Month	•
<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to Coronary artery	2/150 0.30			_	ute to the cause of death?
Division of Vital Records,		Completed	Severe per phère	1 vasculas	discose	24a. Was an autopsy performe	prio ed? dea	re autopsy findings available or to completion of cause of th?
Vita	ician: certific rector,	o Be (	25. Was case referred to medical examiner?		Other	th (Check only one)	)	
ion of		-	1 163 2 2 100	tnpatient 2 ER/Outpatien of Injury oth, Day Year)  28b. Time of Injury Injury	28c. Injury at Work?  M 1 Yes 2 No	ome 5 Residen 28d. Describe how		(Specify)
Divis	or A	Certification:	3 Suicide 6 Could not be determined 28e. Plac	e of Injury - At home, farm, str ding, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Stre City or Town,		or Rural Route Number,
	e Hospital 24 hours a le Funeral l letely filled	edical	(Check only 2   Medical Examiner: On the	e best of my knowledge, death pasis of examination and/or invener stated.	occurred at the time, date and place, restigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manne e and place, and	er as stated. I due to the cause(s)
•	To the within 2 To the complete	Me	29b. Signature and title of certifier  M. Shres Ha.	MD	29c. License number \$20.000 16 278	17	Ton 12	Month, Day, Year)
Q			30. Name and address of person who completed cau M. SHRESTHA. M.D. DEER'S	se of death (ttem 23a) (Type, HEAD HOSPITA	Print) LCENTER SALIS	BURY. N	1d. 218	02-2018
	Sta Registr			Registrar's Signature	Sporker	,		

			For Stata Registrar	State of Mai	ryland		rtment of I		Mental H	ygiene Rag. No	111		03165
			Decedent's Name (First, Middle,	Last)					2. Date of D	eath			3. Time of Death
	Physici		MABEL IN	INCH I	PARSO	NS			JANUA	Day ARV		0 4	11:20 PM
	/Medio Examin		4a. Facility Name (If not institution,				4b. City, Town,	or Location of Dea			. County of [		
	Ladiiii	e.	BERLIN NURSING 8		TION (	CENTER	R BE	ERLIN			WORC	r Cur	₽D
	Funeral				(In yrs. last		If Under 1 Year	If Under 24 Hr		lirth		Birthpla	ace (State or Foreign
	Director		218-16-6186	1□M 2□XF 81		Yrs.	Months Days	Hours Mir	December			Count	vland
-	Þ.		Usual Residence of Decedent	-									
	nytan ihow		10a. State 10b. County		•	Town or Loc						10	Od. Inside City Limits
	Sa-1 s	ct	Maryland Wicon	nico	Pi	ttsvi	lle						1 ☐ Yes 2 XNo
	or 28	Director	10e. Street and Number	1 7 5 7			10f. Zip Code			10g. Cit	tizen of Wha	t Count	ry?
	23a	la	4007 Powell Sc				2185			<u> </u>	USA		
	r deg	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. W	as Decedent of Yes, specify Cut	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	10-	14. Race - A Black, V		
36	or l	by Fi	1 Never Married 2 Married	If Yes, Give	•	11	□Yes 2 🕱No	Specify:		i	Specify:	whi	.te
21215-0036	be filed within 72 hours after death with the Maryland stal hygiene. Id other than "natural", or Itams 23a or 28a-1 show other than "natural", or Itams 23a or 28a-1 show evant, the Medical Examination in the field of the standard of the s	g p	3 Widowed 4 Divorced	Year or Dates:	1 .	16a Dagada	nt's Usual Occu	nation		165 1			
-5	n 72 "nai	Completed	15. Decedent's (Specify only highest	grade completed)		(Give k.	ind of work done  O NOT use retire	during most of ward)	orking	100. K	ind of Busin	essylno	ustry
12	withi ene. then	Ę	Elementary/Secondary (0-12)	College (1-4or 5+	)	Homen		/		Do	mesti	_	
d ⊢	filed Hygi other	ပိ	17. Father's Name (First, Middle, La	st)		Homen	Idver	18. Mother's Na	ame (First, Middi				
MABEI aryland	Mental Mental arked c	To Be	Charles P. Tim	mons				Nora L	. Little	eton			
<b>₹</b>	2 shoutd and Mer is marke sumatic	ř	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Stree	t and Number or F	Rural Route Num	ber, City o	or Town, Sta	te, Zip (	Code)
\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	od 2 string		John E. Parsons/			-		School		-			
	1 and Health tam 27 other tr		20a. Method of Disposition	11abbana	20b. Plac	e of Disposi	tion (Name of		Date	20c. Lo	cation - City	or Tov	Mn, State
PARSONS Baltimore, I	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic evant, the Mudical Examilisation usits a malified at any		1 □xBurial 2 □ Cremation 3  1 □ Donation 5 □ Other (Spe		Far	Low Ce	emetery	1/1	8/04	Pi	ttsvi	lle,	, MD
AR	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Li		1	22.	Name and Addr	ess of Facility				·	
д В	permit. Departn Imports any inju		10 -0 21 10 m	come Ci	SP	5	01 Snow	Hill Rd	Home Pr	cotes	siona.	LAS	sociation
			23a. Part1. Enter the disease, or co	omplications that caused to	he death. I						/ 1110		Approximate
	Discolates		shock, or heart failure. List or Immediate Cause (Final	nly one cause on each line	1	i i	C. 1:	rascula,	Alter				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	Acro		ATO 101	12704 la	1013000	۶(		-	Trees
	Examiner			Due to (or as a	consequen	ice oi).							
		e	Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequan	nealor):							
	d ansit	Ë	Cause (Disease or injury that initiated events										
ć	cate be executed physician and the burial-transit	Examiner	resulting in death) Last	Due to (or as a	consequen	nce of):							
8760,	cate be ex physician the buria	dlcal		d									
68	ifficat g phy as th	ed											
ŏ	h cer endin	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2			ectopic pregnanc	3/			23d. Date of		,
<u>.</u>	deat	Sicle	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐ Pregnant at ti			Other (specify)	·,			Month		Day Year
Ö	at the by the	چَ	9 ☐ Unknown *										
S,	ures that the death certifi signed by the attending I d be detached for use as	by Physiclan/Me	Part II. Other significant condition	s contributing to death but	not resulting	ng in the und	derlying cause gi	ven in Part I.					e cause of death?
rd	w require been si should i								1 2	Yes 2	□No 3	] Proba	ibly 4 Unknown
ပ္စ	law ri as be 2 sh	Completed							24a. Wa	s an opsy	24b. Wer	autop:	sy findings available
Ĕ.	The ate his	ē							per 1 ☐ Yes	formed?	deat	h?	2□ No
ita	sician: The law certificate has b irector, page 2 s	Be C	25. Was case referred to medical examiner?					26. Place of De	eath (Check only		<u> </u>		×
<b>2</b>	nysic als ce direc	To	1 ☐ Yes 2 XNo	Hospital: 1  Inpatient	t 2 ER	VOutpatient	3□ DOA Ot	her: 4. Nursing	Home 5 ☐ Res	sidence	6 □Other (	Specify)	1
0	ding Phys n. After this funeral di		27. Manner of Death  1√□ Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28	Bb. Time of Injury	28c. inju	iry at Trock?	28d. Describe	how injur	ry occurred		
Ö	andii eath. or: Ai	atle	2 Accident investiga				M 1	]Yes 2 ☐ No					
Division of Vital Records, P.O. Box	or Attand after death Diractor: /	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of Injur	y - At home (Specify)	e, farm, stree	et, factory, office			(Street and		r Rural	Route Number,
	ital o irs aff ral Di led ir	Š		<b>V</b>					A)				
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Diractor: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier Certifying (Check only one)	Physician: To the best of caminer: On the basis of e and manner state	examination	edge, death and/or inve	occurred at the t estigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time	e cause(s) e, date and	) and manne d place, and	r as sta due to t	ited. the cause(s)
_	To tha within 2 To the comple	Med	29b. Signature and title of certifier	state state			29c. Licen	se number		29d. Dai	tersigned (M	logth, D	ay, Year)
	- 5 - 0		NH Miles	leda 10	2	>	Do	58760	7	- 1	115	100	-
			30 Name and address of person w	no completed cause of dea	ath (Item 23	3a) (Type P	rint)	219 (	Bourte	1 14	ishe.	rous	·
ODQ			Nicholas N	Board	1110	. ///	D F	- eaunit	TI	cent	no	7	19944
W J G	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1		7-100101			/ /	! -	
	Regist		IAM 1.0	2001 Gens	war	4	Some	2					
DH	MH 17 Rev 1/2	001	JAIN 1 0	2004		/-	//						

ORIGINAL

		For State Registrar	State of Ma	arylar				lealth and Death	Menta	l Hygie	6. 6	104	031	66
Physicia		1. Decedent's Name (First, Middle, Las							2. Date Mon	of Death	Day	Year	3. Time of	Death
/Medica		RONALD B.	PHILLIPS						01	/	6	04	0038	М
Examine	er	4a. Fecility Name (If not institution, give RN/NSUIA REGIONA)	street and number)  MU/IN	1 16	MAI	4b. City,	Town, or	A LISSU	nath (M)			ty of Death		
Funeral		Social Security Number     6. Security Number	9x 7. Ag K∑M 2□F		last birthday)	If Unde Months	1 Year Days	If Under 24 H	fs. 8. Date in. (Mor	of Birth	ar)	9. Birth	place (State or	r Foreign
Director		Usual Residence of Decedent	<b>₽</b> IW 2□1	84	Yrs.					-25-19			<u> Jerse</u>	
arylan •how	<b>.</b>	10a, State 10b, County		10c. Cit	ty, Town or Lo	cation							10d. Inside Cit	•
S the Mg the Mg couling	cto	Delaware Sussex		Se	aford								1 🗍 Yes	2X No
30 with th	Funeral Director	10e. Street and Number				10f. Zip				10g.	Citizen of	What Cou	ntry?	
S / S	era	22693 Bloxom Scho	DOL Rd 12. Was Decedent	Ever in H	C 1+2	Was Dass		9973	(Casati Va	No	U:		ann taolian	
SYOS/	Ĕ	1 Never Married 2 XMarned	Armed Forces?		.5.	If Yes, spe	cify Cuba	ispanic Origin? In, Mexican, Pu	erto Rican, e	tc.)		ack, White,	can Indian, etc.	
5-0036 72 hours all natural; or alreal and	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1945	1 🗌 Yes	<b>2√0</b> √No	Specify:			Specia	ify:	White	
5-0036 72 hours after death with the Maryland natural; or teme 23e or 28e-1 show dical Examiner must be multiled at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece	dent's Usu	al Occupa	ation	vodkina	166	. Kind of E	Business/In	dustry	
2121 d within giene. or then	du l	Elementary/Secondary (0-12)	College (1-4or 5	5+)			se retired	during most of w	orking.					
nd 2121 nd 2121 litygiene. other then 'rent, the Me	ပ္ပ	17. Father's Name (First, Middle, Last)			Fa	rmer		10. Mothada N	lana (First A			Owner		
₹ \$ ± \$ ± \$ \$ 1	To Be	Edward H. Phill:	ins					18. Mother's N	se Whea		ien Sumai	me)		
aryla aryla should nd Men nd Men umatic umatic	۲	19a. Informant's Name/Relationship (7			19b. Mailir	na Address	(Street a	and Number or I			tv or Town	State Zir	Code	
re, Maryla re, Maryla s 1 and 2 should Health and Men Item 27 is marke other traumatic			- wife					School						
ore, M es 1 and 2 of Health fleen 27 i		20a. Method of Disposition		20b. F	Place of Dispo				Date		•	- City or To		
Page Dent country or rry or		1 ∑Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify						tery 01	/19/20	004 M	li1tor	n, DE		
Baltimol permit. Pages Department of Important: If any injury or once.	Ì	21. Signature of Funeral School Licen	see Lan	1	22			s of Facility	1					
00 89 2 8 9		23a. Part 1. Enter the disease, or companions, or heart failure. List only of	ston	- 0		Cran	ston Boy	Funera	I HOME	DF 1	9973			
System of the brightness of th	dical Examiner	snock, or near tailure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as  b. Due to (or as  c. Due to (or as  d.	a conseq	A Rey uence of):	AE	76	Ref	DISE	APE			Interval Betwo	
Vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed refeath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3□	]Ectopic pr ] Other (sp						ate of delive	-	ear
cords, F wrequires that been signed should be det	2	Part II. Other significant conditions co	entributing to death be	ut not res	ulting in the ur	nderlying c	ause give	n in Part I.	23e.	Did tobacc		tribute to th	ne cause of dea	
aw requise been 2 should	Completed								24a.	Was an	24b.	Were auto	psy findings av	vailable
Rec The lav	é								10	autopsy performed Yes 200	?   (	prior to cor death? 1 \( \sum \text{Yes} \)	mpletion of cau 2□ No	150 01
Vital Filting The incient: The certificate rector, page	Be	25. Was case referred to medical examiner?		-				26. Place of De						
Of V Physic this of al dire	9	1 ☐ Yes Z No	Hospital: 1 ☐ Inpatie		ER/Outpatien			4 🗆 Nursing	Home 5□	Residence	6 □Oth	ner (Specify	1)	
Jing F	0	27. Manner of Death  1 SNatural 5 □ Pending	28a. Date of Injur (Month, Da)	Year)	28b. Time of Injury		8c. Injury Work		28d. Desc	cribe how in	jury occuri	red		
Division of Vital Records, To the Hospitel or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At ho	ome, farm, stre	M eet, factory		′es 2 □No	28f. Local City of	tion (Street or Town, Sta	and Numb ate)	per or Rura	l Route Numbe	er,
Hospi 24 hour Funer etely fills	Medical	29a. Certifier (Check only one) Certified Physics (Check only one)	rsician: To the best of iner: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred restigation,	at the time in my op	e, date and place inion, death occ	ce, and due to curred at the	o the cause time, date a	(s) and ma ind place,	anner as st and due to	ated. the cause(s)	
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			5	Ma	HAN K	) XH47	055	200		JA	NUI	4RY	16 20	04
IVA		30. Name and address of person was	mpleted cause of de	eath (Item	23a) (Type, I	Print)	0					- (-	1	
10+1VA		614-B - EA	TERN S	HOP	E DR	IVE	5	ALISB	URY.	NO	) 2	180	4	
State Registra	e r	31. Date filed (Month, Day, Year) JAN 2 0	mpleted cause of de TCR 2004 32. Registra	r's Signa	ALLE ALLE	1 4	pai	Est	,					

		1	For State Registrar	State of Ma	ryland /	Depar <i>Certi</i>	tment of ficate of	Health Death	and M		giene Reg. No.		, i	03167
D.	ioioir		1. Decedent's Name (First, Middle, La	•						2. Date of Dea	Day	Yea	.	3. Time of Death
	iysicia Medic	al		ne Polek						January	-			10:05 a <sup>M</sup>
Ex	camin	er	4a. Facility Name (If not institution, giv			4	lb. City, Town,				4c.	County of De		
			10191 Crab Islar 5. Social Security Number 6. S		(In yrs. last bi	irthday)	Princ If Under 1 Year	Cess A	nne	9 Date of Birth	h	Somer		
	neral ector			□ M 2 13 F 4			Months Days		Min.	8. Date of Birth (Month, Day September				ce (State or Foreign
	CLOI		Usual Residence of Decedent							September	. 2/1.	2.30   Ma	ary.	Land
rylanc how	3		10a. State 10b. County		10c. City, Tov	n or Loca	tion						100	I. Inside City Limits
e Ma	iffec	ᅙ	Maryland Somers	et	Princ	cess	Anne							1 ☐ Yes 2 ☑ No
it th	20.80	Dire	10e. Street and Number				10f. Zip Code				10g. Citi:	zen of What (	Country	y?
ath w	ast	2	10191 Crab Islan		1.110	10.101	2185		1-1-0-10-		US	A 14. Race - An		Ladica
paritimities, Mai yitaling 21213-0030 parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	o Jections	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent & Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		If Y	is December of ces, specify Cul	ban, Mexica	ın, Puerto	ecify Yes or No- Rican, etc.)		Black, Wh		c.
hour	al E		15. Decedent's E		16a	a. Deceder	nt's Usual Occu	pation			16b. Kir	nd of Busines	s/Indu	strv
in 72	Aedis	Completed	(Specify only highest gra	ade completed)		(Give kir	nd of work done NOT use retin	a during mo	st of worki	ng				,
d with	the	E O	Elementary/Secondary (0-12) n/a	College (1-4or 5+		n/a					n	/a		
a Hys	vent,	Bec	17. Father's Name (First, Middle, Last	)				18. Moth	er's Name	(First, Middle,	Maiden	Sumame)		
Ments	atic e	၉	Leon John Polek					Ann	Mar	ry Whes	stle	Ÿ		
2 should and	raum		19a. Informant's Name/Relationship ( Susan Polek Whit			_				Prince				
1 and 1 and Health	ther		20a. Method of Disposition	e/ Biblei		-04-00	ion (Name of tory or other pla			ate		cation - City		
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mit. F partme portan	y injur		21. Signature of Funeral Service Lice	**	Darrok	22. N	lame and Addr	ess of Facil	lity					
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	4		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused to on cause on each line	the death. Do	not enter	the mode of dy	ing, such a	s cardiac c	r respiratory ar	rest,		l Ir	pproximate hterval Between
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/Med Exam			resulting in death)	Due to (or as a										TIOHEIIS
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sxecu n and	al-tra	Examiner	resulting in death) Last	C. Due to (or as a			IX.						-44	4 years
cate be executed	the burial-transit	call		d										
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th cer tendir	r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		h 3∐Eo	ctopic pregnanc	СУ			2	3d. Date of d		
e deatl	detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown	ime of death	5 🗆 C	other (specify)					MORRIT	D	ay Year
hat th	fetach		Part II. Other significant conditions	contribution to death but	t not resulting	in the unde	arlying cause g	Iven in Part		23e Did to	bacco u	se contribute	to the	cause of death?
The law requires that the death certificate has been signed by the attending	should be deta	d by	MENTAL RETARDAT		. Hot rooming	With the terror	onywig oddoo g		**		_	_		ly 4 ∐Unknown
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he lay	(7)	Completed								autop	sy med?	prior to	comp	eletion of cause of
VILCII ician: T sertificate	or. pa	e C	25. Was case referred to medical				<u> </u>	26 Plac	e of Death	1 Yes	2 🔯 No	1 🗆 Ye	s 2	LI No
Ot VII.d Physician:	direct	0 8	examiner? 1 Yes 2 X No	Hospital:	t 2 ER/O	utpatient	3 DOA	ther		ne 5 X Resid	-35	Other (Sc	ecify)	
E Programme of the contract of	the funeral director, page	n: T	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Inju	ury at	- 1	28d. Describe h	ow injury	y occurred		
Attending r death.	n) eq	atic	2 ☐ Accident investigatio	n				Yes 2	]No					
olvis al or Att	d in by	Certification:	3 Suicide 6 Could not be determined		ry - At home, f (Specify)	arm, stree	t, factory, office	•		28f. Location (S City or Tow	treet and n, State)	d Number or I )	Rural F	Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A	completely filled in by	edical (	29a. Certifier 12 Certifying Pl (Check only one) 2 Medical Example (Check only one)	nysician: To the best of miner. On the basis of and manner state	examination a	ge, death o nd/or inves	ccurred at the stigation, in my	time, date a opinion, de	nd place, a ath occurre	and due to the c ed at the time, c	ause(s) late and	and manner and di	as state	ed. ne cause(s)
To th withir To th	comp	Me	29b. Signature and title of certifier	1				nse number		4	29d. Date	e signed (Mo	nth, Da	y, Year)
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À			30. Name and address of person who					C-1	i ab	MT O	100	1		
	Sta	to	Dr. Jock Simon, 31. Date filed (Month, Day, Year)						ISDUL	y, MD 2	.TQU4	±		
Re	ાa egistr			2004 32. Regisfrar	market	Ø	Spa	K						

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			Decedent's Name (First, Michael Control of the	dle, Las	t)							2. Date of Dea			1 10/2	3. Time of Death
	Physici		Angeline S. Pu	αh								Month January	Da 7 20	y 200	ear /	8:00 AM M
	/Medic Examin		4a. Facility Name (If not institut		street and nun	nber)		4b. City,	Town, or	Location	of Death	oanaar		. County of		0.00 AT
	Exam.		23 Yellow Fiel	d Bo	ulevaro	1			E1kt	on				Cec	i 1	
	Funeral		5. Social Security Number	6. Se	×		s. last birthday)		1 Year	If Under Hours	24 Hrs.	8. Date of Birt (Month, Da	h V Vear			place (State or Foreign
	Director		219-42-0427	1[	⊐м 2 <b>Х</b> ДГ	81	Yrs.	MONUIS	Days	Hours		ugust 2	23,	1922	D	elaware
	D *		Usual Residence of Decedent  10a. State 10b. Coun	h		100.0	City, Town or Lo	eation								0d. Inside City Limits
	ehov	5		•	_	100.0										1 ☐ Yes 2XOXNo
	he M	Director	Maryland   10e. Street and Number	Ceci	.1		E1kt		0-4-				10- 0	hi		
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Ŏ	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f ehow ha Medical Exami ar mast be notified at	Completed by	15. Deced				16a. Dece	dent's Usua	al Occupa	ation			16b. k	(ind of Busin	ness/In	dustry
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nd	be fill htal H	Be	17. Father's Name (First, Middl	ə, Last)						18. Mothe	er's Name	(First, Middle,	Maider	n Sumame)		
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Maryland 21215-0036	C/ C 75 00	0.3	19a. Informant's Name/Relatio					-				d Route Numbe				
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ō	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ABurial 2 ☐ Cremation			State No.	Place of Dispo cemetery, crer orth Eas emetery	natory or of	ther place	e)   ist'J	Tanua	rv 23.	20c. L	ocation - Cit	yoric	own, State
Ę	t. Pa tmen tent: jury		`4 □Donation 5 □Other			Ce	emetery	Je He	LIIOU	130   2	2004	-1, 10,				Maryland
Baltimore,	permit. Departr Importa any inj		21. Signature Juneral Service	e Licens	59°e		- 4					uch Fun				
	TU = 8 G		1 sulo	Ca										ast, l	Mar	y1and 21901
			23a. Part1. Enter the disease, shock, or heart failure. L	or comp st only o	one cause on ea	aused the de ach line.	ath. Do not ent	er the mod	e ot dying	g, such as	cardiac	or respiratory ar	rest,			Approximate Interval Between Onset and Death
1	Physician:	8 1	Immediate Cause (Final disease or condition resulting in death)	_	a. Me	tastati	ic lun	Carr	us							MONTHS
1	/Medical Examiner		Toolking in South,	(	Due to (	or as a conse	equence of):	100								
		-	Sequentially list conditions,	1	b. — Due to (	or as a conse	equence of):								+	
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<u> </u>	axecu and al-tra	xai	resulting in death) Last	1	CDue to (	or as a conse	equence of):								+	
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189	ficate g phy ss the				0											
Вох	The law requires that the death certifica te has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, out									23d. Date o	f delive	erv
m	death a atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐Pregna	rth 2 ☐ Fe ant at time of		]Ectopic pro ] Other (sp						Month		Day Year
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	sician: The law s certificate has b lirector, page 2 s	0	25. Was case referred to medic	al						26. Place	of Death	(Check only or		,1,0	103	20 110
<u>&gt;</u>	Physician: r this certifice ral director, I	To B	examiner? 1 ☐ Yes 2 ☑ No	1	Hospital: 1 ☐ Ir	patient 2[	☐ ER/Outpatien	t 3□ DO	A Othe	-		ne 5 PResid		6 □Other (	Specify	()
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۵	talors aft	Cer												, 		
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical Certification:	29a. Certifier 1 Certify (Check only 2 Medical	ing Phy I Exemi	rsicien: To the iner: On the ba and mann	sis of examir	nowledge, death nation and/or inv	occurred a restigation,	at the tim in my op	e, date an inion, dea	id place, a th occurre	and due to the c ed at the time, c	ause(s late and	) and manne d place, and	er as st due to	ated. the cause(s)
	Tott withii Tott comp	Ň	29b. Signature and title of certif	ier				29c	. License	number		2	29d. Da	te signed (N	fonth, i	Day, Year)
			1 9					D	004	17711			JAN	MARY	22	12004
	10		30. Name and address of person	n who c	ompleted cause	of death (Ite	em 23a) (Type,									
pro-	P		DAVIN GAR-E	L 3	304-306	North	Street	Suit	c # 3	ELH	TON	MARYLA	40	9149	\	
	Sta	te	31. Date filed (Month, Day, Yea		32. Re	gistrar's Sigr	nature									
	Registr	ar	JAN 2 2 2	004	A San	es de	Low	Can De								

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of Ma	aryıarı	•			Death	Wentarry	Reg. No	20	104	00	3169
	Physicia	n	1. Decedent's Name		•						2. Date of De Month	De		Year		of Death
н	/Medic		PA		PITCHFOR					4h City Town of	Location of Deet	12		004 of Death	8:50	O AM
e'	Examin	er			e street end number) NURSING		7D			CHEVERL		1		GEOR	CEIC	2
	Europal		5. Social Security No				E.K. lest birthday		er 1 Year	If Under 24 Hr	s. 8. Date of Bi					te or Foreign
	Funeral Director		219-16-8 Usuel Residence of	116		79	Yrs.	Month	Days	Hours Mir	9 6	192	24 ]	PENNSY	LVA	NIA
	Maryland f show	ō	10a. Stete DC	10b. County			, Town or I HINGT		C					100		e City Limits es 2∛ No
	3a or 28a-	al Direct	10e. Street end Num	nber 55th STRE	ET S.E.	l			ip Code 0019			10g. Cit		Vhat Countr	y?	
020	parmit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiena. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprines must be notified at once.	To Be Completed by Funeral Director	11. Marital Status 1 □ Never Marrie 3 □ Widowed	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	12. Was Decedent Armed Forces? 1 ⊠ Yes 2 ☐ If Yes, Give Yeer or Dates:		S. 13			dispanic Origin? ( en, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	0-		e - American k, White, et	tc.	
Maryland 21215-0020	within 72 ho ena. then "natur re Medical	ompleted	(Speci	15. Decedent's Edify only highest grendary (0-12)	lucation de completed) College (1-4or ! 4	5+)	(Giv life.	edent's Us e kind of w DO NOT	ual Occup ork done use retire	oation during most of wo d)	orking	16b. K		usiness/Indu	stry	
D	Hygi Ather	Č	17. Father's Neme (	First, Middle, Last)	<del></del>			ito i		18. Mother's Na	ame (First, Middle	, Maiden				
<u>lan</u>	lid be fental red or tic eve	0 8	LEVI	PITCH	FORD					LILLI	AN RICHA	ARDS	ON			
Mary	d 2 shouth and N is mark		19a. Informent's Na RUTH V. I				1				Rurel Route Numb				ode)	
ď	Pegas 1 an nent of Haal int: If item 2 iry or other	-	20a. Method of Disp	osition	Removel from State	C	lace of Dispersion of NCOLN	oosition (N emetory or	ame of other pla	ce)	Date 1-17-04	20c. Lo	ocation -	City or Tow		
Baltii	parmit. F Departmo Importan any infur price.	-	21. Signature of Fur		·	7					B. JENK D LANDOV					
			23a. Pert1. Enter the shock, or hear	ne disease, or come t failure. List only	olications that caused one cause on each li	d the death								1	Approxin	
	Physician /Medical Examiner		Immediate Cause (I	Final	RESI	PIRAT	ORY F	AILUR	E							
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P. O.	at the ded d by the letached	Physician/		Cant conditions of INSON'S D	ontributing to death b	ut not resu	ilting in the	underlying	cause giv	ven in Pert I.			_			e of death? ☐ Unknown
Division of Vital Records,	The lew requiras that the death cer ate has been signed by the attendin page 2 should be detached for use	Be Completed by		RTENSION							24a. Was	an autor	psy	avail	lable prid	sy findings or to of cause
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<u>ra</u>	ifficat tor, pa	Ö	25. Was case referr	ed to medical						26. Place of De	eath (Check only					
n of V	hysic pis c	욘	examiner? 1 ☐ Yes 2 ☑ I  27. Menner of Death 1 ☒ Neturel	-	Hospital: 1  Inpatie		ER/Outpation 28b. Time Injury	of	28c. Injui Wo	ner: 4 Nursing y at k?	Home 5 Resi	idence				
VIVISIO	or Atten	Certification:	2 Accident 3 Suicide 4 Homicide	investigation  6 Could not be determined		ury - At ho c. (Specify	me, farm, s	M street, facto		Yes 2 □ No	28f. Location ( City or To			er or Rurel I	Route N	lumber,
	Hospi 24 hou Funer tely fil	Medical Co			ysician: To the best of the be	f exeminat										e(s)
	within 2 To the	Me	29b. Signature and	title of certifier	7			2	c. Licens	e number		29d. Da	te signed	(Month, De	ay, Yeer	r)
	(1)		30 Name and address	stee /	completed cause of d	leath (Item	23e) (Tvo	Print)	D002	26024			1-12	-2004		
2	(IV)		LESTE	R MILES,	M.D. 6490	LANI	OOVER		SUIT	TE F LANI	DOVER, M	ARYL	AND	20785		
	Stat Registra		31. Date filed (Mont	n, Day, Year) 1 4 2004		er's Signe	lure A.	وعمد								

DHMH 16 Rev 6/95

			For State Registrar	State of N	/larylan		artment rtificate			ind M		giene leg. No. 2 (	04	03170
ī	Physicia	an	1. Decedent's Name (First, Middle, L								2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Luis Pedro F	olanco	or)		4b. City, T	own or	Location o		January	8, 200		
	Examin	er	6308 23rd Avenue		,				svil					eorge's
	Funeral		5. Social Security Number 6.		Age (In yrs. I		If Under 1		If Under 2		8. Date of Birth (Month, Day Oct. 23			hplace (State or Foreign untry)
	Director		579-84-6657 Usual Residence of Decedent	IZIM ZLIF	73	Yrs.					Oct. 23	, 1930		eru
	yland now		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	e Mar	ctor	Maryland Prince	George's		Hya	ttsvi	lle						1 X Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip (					10g. Citizen of		untry?
	s 238		6308 23rd Aven	12. Was Decede	nt Ever in II	S 13 5	Was Decede	2078		nin? (Sne	cify Yes or No-	U.S.		rican Indian,
_	r Item de	Funerai	1 ☐ Never Married 2 🕅 Married	Armed Force	s?	1				, Puerto F	cify Yes or No- Rican, etc.)	Bla	ick, White	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Exercit at mast be notified at	<u>a</u>	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1 M Yes 2	□ No	Specify:	Per	uvian	Specil	y: W	Nhite
<u>ئ</u>	natu natu	Completed	15. Decedent's (Specify only highest of	Education rade completed)		(Give	dent's Usual kind of work DO NOT use	done de	uring most	of working	ng	16b. Kind of B	iusiness/l	Industry
12	withir ene. than	dmc	Elementary/Secondary (0-12)	College (1-4d	or 5+)		lousek					Privat	e Bi	ısiness
2	e filed Hygi other	BeC	17. Father's Name (First, Middle, La.	st)				-		r's Name	(First, Middle,			
<u>a</u>	should be Ind Mental I	10 B	Unavailable						Una	vaila	able			
lar)	2 sho and I is ma	8	19a. Informant's Name/Relationship								Route Numbe			(ip Code)
e)	1 and Health em 27 ither tr		Luis S. Salazar	- Son	20b. P	lace of Dispo emetery, crei				C	sville,	MD Z 20c. Location	0782	Town, State
ğ	Pages nent of I ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Special		te MD 1	emetery, cier National	matory`or oth	h <i>er place</i> ial F	eark 0	1/10	/2004	Laurel		
Baltimore, Maryland	그 된 뿐 등 .		21. Signature of Funeral Service Lice		1110						ch's Fu			
m	Depar Impo		Claudette	- Dasch	Jan	ning 47	739 Ba	1tin	ore .	Aveni	ie, Hya	ttsvill	e, M	D 20781
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each a. Metast	n line.	Small				cardiac o	respiratory ari	rest,		Approximate Interval Between Onset and Death  2 Months
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	es a consequ	uence of):								
,092	ate be executed hysician and the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a consequ	uence of):								
687	ificate g phys as the			0										
.O. Box	res that the death certifical igned by the attending phy be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 □Live birth 4 □ Pregnant 9 □ Unknowr	2 ☐ Fetal t at time of d	Ideath 3	Ectopic pre Other (spe						ate of deli	very Day Year
<u>α</u>	quires that the signed by all the detaction		Part II. Other significant conditions	contributing to deat	h but not resi	ulting in the u	nderlying ca	use give	n in Part I.					the cause of death? obably 4 ⊠Unknown
Division of Vital Records,	Physicien: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.	Completed									24a. Was a autop perfor 1 Yes	sy med?	prior to death?	topsy findings available completion of cause of 2 No
Sita Vita	icien: certific ector.	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or			
on of	Jing After fune	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigel	28a. Date of I		28b. Time o		Bc. Injury Work	4 🗀 140	2	ne 5 ☑ Resid 8d. Describe h			cify)
Divisi	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	2 Accident Investiger 3 Suicide 6 Could no 4 Homicide determine	be 28e. Place of	Injury - At ho etc. (Specify	ome, farm, str	reet, factory,	office		2	8f. Location (S City or Tow		ber or Ru	ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (		Physicien: To the be eminer: On the basis and manner	s of examina									
	To the within 2 To the complet	Me	29b. Signature and title of certifier		^	-	29c.	License	number			29d. Date signe		
			SHows	ewan	ma	7		D00	)1995	0		Janua 	ry 9	, 2004
ر -			30. Name and address of person with Susan Houseman,					enue	e, 6t	h Flo	oor, Wa	shingto	on, I	OC 20037
	Sta Regist		31. Date filed (Month, Day, Year)  JAN 1 4 2004		istrar's Signa	free	e .							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month Year **Physician** January 7, 12:02 P M Johnny L. Pogue /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year, 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 10XM 2□ F 1939 Mobile, Alabama June 01, Director 64 418-44-1669 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or Items 23a or 28e-f show Exeminer must be notified at 1 ☐ Yes 2 ☐ No Director Capital Heights Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743 U.S.A. Fable Street 4918 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1≱Yes 2 ☐ No A11my Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Ite any injury or other treumatic event. It a Medical Francis 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) PASTOR Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bonnie L. Pogue Sr. (Rev.) Alma Houston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3503 St. John's Place Landover, Maryland 20782 Helena Starling/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 1-17-04 Moble Alabama 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 30785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Intraccanial resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 No Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral C filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO 53 813 nars JUMAN MD January 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Surratts Road Clinton, Maryland Mark Dumais M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Day</sup> 2004 **Physician** JAN. 11, **MERTISE** POWELL 2:09 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE SOUTHERN MARYLAND HOSPITAL **CLINTON** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day Year) 12-15-51 Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 231-78-0206 52 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov MD PRINCE GEORGE OXON HILL 14 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other then "natural", or iteme 23a or other traumatic event, the Medical Examinar must be 1271 SOUTH VIEW DR. #101 20745 u. S. A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK Maryland 21215-0036 ρ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry TOTH GRADE (0-12) College (1-4or 5+) SIGHT REPRESENTAIVE XEROX Department of Health and Mental Hyg Important: If Item 27 is marked other only injury or other traumatic... 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JAMES R. POWELL MERTISE O. HIGH 19a. Informant's Name/Relationship (Type, Print)
ARNITA POWELL—-DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8610 PAMPER LANE FT. WASHINGTON, MD 20744 altimore, 20a. Method of Disposition

→ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State LINCOLN MEMO. CEMETERY 1-17-04 SUITLAND, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 21. Signature of Funeral Service Licensee 524 - 8TH ST., N.E. WASHINGTON, DC 20002 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive **Physician** End stay Unknow-/Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of) Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy detached for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Whiknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 ₽No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatrent 3 ☐ DOA Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 43446 Rointer Fach M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 9801 Georgia Ave Suit 3-41 Solver Spring MD 20902 ROINTAN FARAHUFAR 31. Date filed (Month, Day, Year) JAN 1 5 2004 \$2. Registrar's Signature State Registrar

State of Maryl

Certificate of Death	Reg. No. 2004	3. Time of Death
	Month Day Year	1 10-123 M

111 Penn Street, Baltimore, Maryland 21201

**Physician** /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ira Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending physician and completely lilled in by the funeral director, page 2 should be detached for use as the burial-tran

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar			Certi	ficate of	Death	F	Reg. No.	UU4	031/3
	1. Decedent's Name (First, Middle, Last)						2. Date of Dea		V	3. Time of Death
an	Warren William Ed	ward Reib	some				Month Janua	Day ary 26	Year 2004	10:13A M
al er	4a. Fecility Name (If not institution, give s	street and number)		4	b. City, Town, o	r Location of Death			inty of Death	1 10 110
	St. Mary's Hospit	al			Leonard	town		S	t. Mar	v's
	5. Social Security Number 6. Sex	7. Age	(In yrs. last birt	hday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey	Year)	Cour	lece (State or Foreign
	175 <b>–</b> 34–8890	[M 2□F   6	50 y	rs.	violitis Days	Tiodis Will.	January 2	27, 194	3 Penns	ylvania
	Usuel Residence of Decedent		10- C't T							Od Inside City Limits
_	10a. State 10b. County		10c. City, Town						'	0d. Inside City Limits 1 ☐ Yes 2X No
cto	Maryland St. Mary's	S	Leonar	dtov						
Oire	10e. Street and Number				10f. Zip Code			-	of What Cour	itry?
To Be Completed by Funeral Director	40755 Magee Drive				206				USA	
Ine	The Maritan States	<ol> <li>Was Decedent 8 Armed Forces?</li> </ol>		13. Wa	is Decedent of F es, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
YF	1 Never Married 2 Married	1 XYes 2 N If Yes, Give	lo	1 🗆	]Yes 2█ No	Specity:		Spe	ecity: Whi	te
d b	3 Midowed 4 □ Divorced	Year or Dates:	1							
lete	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>	16a.	(Give kir	nt's Usuat Occup nd of work done NOT use retire	during most of work	ing	16b. Kind o	f Business/Inc	dustry
dm	Elementary/Secondary (0-12)	College (1-4or 5	+) Dep			ance Offi	cer	Federa	1 Gove	rnment
ပိ	12 17. Father's Name (First, Middle, Last)		РЧ			18. Mother's Nam				
Be						Catherin				
ď	John Augustus Reil									
	19a. Informant's Name/Relationship (Ty			_		and Number or Rur venue, MD		r, City or To	wn, State, Zip	Code)
	Tracy Lee Guy/Daug	ilcer					Date	20a Laasii	o City or To	um Stata
	20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	lemoval from State	cemeter	y, crema	ion (Name of tory or other place	<sup>ce)</sup>   1/30	/2004		on - City or To	
	* 4 ☐ Donation 5 ☐ Other (Specify)		Charle	s Me	morial	Gardens	. )1			Maryland
	21. Signature of Funeral Service License		$\bigcap$	22. N	Name and Addre	P.O. Box	270 Leona	rdtown	, Maryla	nd 20650
	Michael Heven	Hadin	1						-	
	23a. Part1. Enter the diseas or compli shock, or heart failure. List only or	ne cause on each tin	ie.	ot enter	the mode of dyir	ng, such as cardiac	or respiratory ari	rest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	MYPERT	ENSIVE	A	THERASC	LEROTIC	MARDIOL	/ASCU.	AR	onest and south
	resulting in death)		a consequence o					DISEA	2Œ	
	Sequentially list conditions.	o								
lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of	of):						
am	Cause (Disease or injury that initiated events resulting in death) Last									
Ω.	1850king in death) cast	Due to (or as	a consequence o	); (10						
Medical Examiner		d	-							
Med	IF FEMALE:									
an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1□Live birth		3 □ ∈	ctopic pregnanc	у			Date of delive Month	nry Day Year
sici	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 🗆 C	Other (specify) _					<i>Du</i> ,
Completed by Physician/	9 Unknown			46			an- Dida-	h		a serves of death?
by	Part II. Other significant conditions con	ntributing to death be	ut not resulting in	the und	eriying cause giv	ren in Part I.				ne cause of death?
ted							1 U Y	es 2 No	0 3   Prob	abiy 4 DUnknown
ple							24a. Was a autop		b. Were auto	psy findings available inpletion of cause of
E O							perfor	med? 2 No	death?	
Be C	25. Was case referred to medical					26. Place of Deat			,	
ToB	examiner?  **EXYes 2 No	łospital: 1 ☐ Inpatie	nt 2 XX RVOu	tpatient	3□ DOA Ott	ner: 4 Nursing Ho	ome 5 Resid	ence 6 🗆	Other (Specify	<i>(</i> )
. : u	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. T	ime of	28c. Injui	y al	28d. Describe h	ow intury oc	curred	
atio	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(,)		()		Yes 2 □ No				
ific	3 Suicide 6 Could not be determined	28e. Ptace of Inju-	ury - Al home, fai	rm, stree	t, factory, office		28f. Location (S City or Tow		imber or Rura	l Route Number,
Serl		Dandary, etc	. (OPOUNY)				5, 5. 101	, 0.0.0/		
al (	29a. Certifier 1 Certifying Physical Control of the Certifying Physical Certifical									
Medical Certification:	(Check only XX Medicel Exami	ner: On the basis of and manner sta	examination and ited.	Vor inve	stigation, in my o	ppinion, death occur	red at the time, o	ate and plac	ce, and due to	me cause(s)
M	29b. Signature and title of certifier				29c. Licens	se number	- 2	29d. Date sig	gned (Month,	Day, Year)
	I areal	-			o.c.	M.E.		Janua	ary 27,	2004



State Registrar

ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBIO, MD

ANA

31. Date filed (Month, Data)

			For State Registrar	State o	f Marylan		artmen rtificate			and Me		giene 2 Reg. No.	004	03	174
	District in		1. Decedent's Name (First, Middle	, Last)							2. Date of Dea	Day	Yeer	3. Time o	
	Physici /Medi		George Edward								Januar		2004	67:40	Ам
	Examir	ner	4a. Fecility Name (If not institution		mber)		4b. City,	Town, or	Location o	f Death			inty of Deet		
			Saint Mary's F 5. Social Security Number	lospital 6. Sex	7. Age (In yrs.	last birthday)	Lec If Under		Itown If Under:	24 Hrs.	8. Date of Birt	th.	nt Ma 9. Birtl	nolece (State	or Foreign
	Funeral Director		578-12-8005	1 <b>X</b> M 2□F	87	Yrs.	Months	Days	Hours	Min,	(Month, Da  June 9		Co	untry) yland	
	D		Usual Residence of Decedent	-		- <del>-</del>								10d. Inside C	Situ & Impite
	arylat ahow	5	10a. State 10b. County			y, Town or Lo									2 🗆 No
	the M	ectc	Maryland Saint  10e. Street and Number	Mary's	Lec	nardto	10f. Zip	Code				10g. Citizen	of What Co	untry?	
	with with the control		22361 Bayside F	Road				20650	)		1	U.S.A		,	
	death ms 2;	Funeral Directo	11. Marital Status	12. Was Deci	edent Ever in U.	S. 13.				gin? (Spec	cify Yes or No lican, etc.)			ncan Indian,	
ဖွ	or ite	교	1 ☐ Never Married 2 X Marr	ied 1 X Yes If Yes, Gr	2 🗌 No		1 ☐ Yes :		Specify:	, Fuento F	iican, etc.)		ecify:	s, etc.	
003	nours ural',	d by	3 Widowed 4 Divorced	Year or D	ates: 1944-	-1946							Wh	ite	
7	n 72 ł	Completed	15. Decedent (Specify only highes	st grade completed)		(Give	dent's Usua kind of wor DO NOT us	rk done d	uring most	of workin	g	16b, Kind C	of Business/	industry	
12	withi	d mo	Elementary/Secondary (0-12)	College (	1-4or 5+)		Super					Ci	vil S	ervice	
þ	should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other than "natural", or items 23a or 28s-f ahow unastic event, the Madical Exercities must be notified at	Be C	17. Father's Name (First, Middle,	Last)		,			18. Mothe	r's Name	(First, Middle,				
<u> a</u>	uld be Venta rrked ritic av	To B	George L. Rale	<b>2</b> у					Mar	tha R	usse11				
<u> </u>	2 sho and 1 s ma		19a. Informant's Name/Relations				•				Route Number				
2	of Health of Health I Itam 27 I		Carl Raley /	Son	20h P	414(			Lane		nardto		0 2065 on - City or		
or s	Pages 1 nent of H int: if its iry or ot		20a. Method of Disposition  1 Bunal 2 Cremation		State	emetery, crei	matory`or o	ther place							
Baltimore. Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene.  Department of Heath and Mental Hygiene.  Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f ahow any injury or other traumatic avant. Its Macical Exercities must be notified at once.		' 4 □Donetion 5 □ Other (S	pecity)	St.	Franc	Cis Ce	emete	ery (	01/07	//04 sfield	Leonar	dtown	, Mary	land
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	Time I		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deet				-				iry ild	Approxima Interval Be	ite
	Physician		Immediete Cause (Final disease or condition	D	1 / 1 4 //	mia	Media	lu	i hav	11111	-			Onset and	
	/Medical		resulting in death)	Due to	(or as a conseq	uence of):	Level	- VIII	por	)				0	
	Examiner	L.	Sequentially list conditions, if any, leading to immediate	b. Cu	gestin	I K	ممد	X-	tau	turi				1 lek	4
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	d Due to	(offas a conseq	uence or):	1. 6							Zhu	1
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):	Lign	au	ey					2- 17-(	<i>)</i> •
760	ate be executed hysician and the burial-transit	ical E			)		V				Andrew Co.				
89				U											
Box	aw requires that the death certifical as been signed by the attending phase should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		⊒Ectopic pr	egnancy				23d.	Date of del	ivery Day	Year
	ne dea the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregr	nant at time of d	leath 5[	Other (sp	ecity)					MOM	Day	1 041
RALEY	that the ed by th detache	Phy	Part II. Other significant condition	ons contribution to d	leath but not res	ulting in the u	inderlying c	ause dive	en in Part I		23e. Did t	obacco use	contribute to	the cause of	death?
Т.	requires that seen signed hould be de	d by	Atuil ?	Libraill	atron			<b>3</b>			1 🗆	Yes 2□N	o 30 <b>1</b> 0	obably 4	]Unknown
GE	v requ been shoulk	etec	Di Carres	1000	Lili	turo	234				24a. Was	an 2	4b. Were au	topsy findings	available
GEORGE I Record	The law ate has b	Completed	7 000000	race p	Merci	· ferres	1001				autor perfo	osy rmed3	prior to death? 1 ☐ Yes	completion of	cause of
Vital	ician: Th certificate rector, pag	(a)	25. Was case referred to medica	ı					26. Place	of Death	1 ☐ Yes (Check only o	2 No	1 🗆 1 62	2 140	
5	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DC	Othe	er: 4 □ Nu	rsing Hom	ne 5 ☐ Resi	dence 6	Other (Spec	cify)	
Division of	ding Phys	:uc	27. Manner of Death 1 SAlatural 5 □ Pendir	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	of 2	8c. Injury Work	/ at </td <td>2</td> <td>8d. Describe</td> <td>how injury or</td> <td>curred</td> <td></td> <td></td>	2	8d. Describe	how injury or	curred		
i.	Attending r death. ector: After by the fune	Certification:	2 Accident investi	gation			М		Yes 2□		D( ( )	Ch		- I Davida Mu	
	or At or At or At or At or At or At or At	in in	4 Homicide determ	nined 200. Flau	e of Injury - At h ling, etc. (Specil	ome, tarm, st fy)	reet, factor	y, office		2	8f. Location ( City or To		umber or Hu	irai Houle Nui	TIDer,
_	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifyin	ng Physicien: To the	e best of my kno	owledge, deat	th occurred	at the tim	ne, date an	d place, a	nd due to the	cause(s) and	manner as	stated.	
	e Hos 24 h e Fur letely	Medical		Exeminer: On the b											(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie	or O			290	c. License	e number			29d. Date si	gned (Monti	h, Day, Year)	
			todan l	Lem	uch in	$\bigcirc$	-	De	13	80		1.5	-00	1	
15	)		30. Name and address of person JOHN F. FENWICK		se of death (Iter		Print)	ART	'S BLI	)G. T.	EONARD'	TOWN - M	D. 206	50	
	′		31. Date filed (Month, Day, Year)		P.U.BUX					- О• П					
	St Regis	tate trar	IAN (		maryiatidi a aiyini	H A	back	,							

				Please  1 - State Registrar	State of M	aryland / D		nt of H	ealth and M	lental Hy	•	OL	03175
		Dhuaic		1. Decedent's Name (First, Middle, La.			DEED			2. Date of Dea	ath Day	Year	3. Time of Death
		Physici /Medi				IRGINIA					14, 20	04	1:30 P <sup>M</sup>
U		Examir	ier	4a. Fecility Name (If not institution, giv		_			Location of Death		4c. County		
		Funeral		CARROLL HOSPIT  5. Social Security Number 6. S	ex _ 7. Ac	R ge (In yrs. last birtl	nday) If Unde	r 1 Year	MINSTER If Under 24 Hrs.	8. Date of Birt	h	ROLI 9. Birth	plece (State or Foreign ntry)
		Director		213-09-5423	□M 2X1F	91 Y	rs. Months	Days	Hours Min.	5 / 2 4 /	1912	MAF	RYLAND
		and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
		Manylan -f ehow	tor	MD. CARRO	LL	FINKS	BURG						1 ☐ Yes ¾(∑No
		after death with the Maryla or Items 23a or 28a-f ehor miner must be notified at	Director	10e. Street and Number		-l	10f. Zi	p Code			10g. Citizen of	What Cou	ntry?
		ath w			INSTER P			2104			US		
		items Items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces	Ever in U.S.	13. Was Dece If Yes, spe	dent of Hi orfy Cuba	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Rad Bla	ce - Americk, White,	can Indian, etc.
	5-0036	72 hours after death with the Maryland fratural', or Items 23a or 28a-f show dical Examinat must be notified at	þ	3 ☐ Widowed 4 ₹ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 <b>⊠</b> No	Specify:		Specif	v: WF	HITE
	2-0	72 ho 'natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. I	Decedent's Usu (Give kind of wo	al Occupa	ation Juring most of worki	na	16b. Kind of B	usiness/In	dustry
_	121	within ene. then."	mpi	Elementary/Secondary (0-12)	College (1-4or		Inte. DO NOT	ise retired JSEW	)		HOME M	AKEF	2
660	d 21	filed Hygi thar	Be Co	17. Father's Name (First, Middle, Last)			110	022.1	18. Mother's Name				
a.	lan	± 5 €	To B	JO	HN		HALE		LILL	ΙE	ASHE		
Virginia Reed	Maryland	and and is m	. 3	19a. Informant's Name/Relationship (	**								Code) 21048
Viac		1 an Heal am 2		ROMAINE BECKER  20a. Method of Disposition	- DAUGH		/4 OLD Disposition (Na		TMINSTE	R PIKE	20c. Location		
Avis	Baltimore,	8 - = 0		1 ☐ Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specific		cemetery	, crematory or o	other place	ATION 1/			•	
X	altir	permit. Page Department of Important: If any injury or once.		21. Signature of Farral Service Licer		V			s of Facility $\mathbf{FLE}$				
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	ı			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each li	d the death. Do no ine.	ot enter the mod	de of dying	g, such as cardiac o	r respiratory ari	rest,		Approximate Interval Between
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a CH	18							Onset and Death
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			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence of	).	(10()	(1)		-		
		e be executed rsician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· A	who .	and the second second second second	931	2				
	60,	be exe ician a burial-	a Ex	resuming in death) Last	*	a consequence of							
	68760,	ficate g phys is the			.d	emen	14						
	Вох	Hospital or Attending Physician: The law requires that the death certificate 1.4 hours after death. 44 hours after death. Funaral Diractor: After this certificate has been signed by the attending physitely filled in by the funeral director, page 2 should be detached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2  Fetal death	3 □Ectopic p	recessory			23d. Da	te of delive	əry
	O. B	e deal the att	sicis	in the past 12 months? t □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant a		5 Other (s				Мо	nth	Day Year
	P.O.	w requires that the deben signed by the should be detached	Phy	Part II. Other significant conditions of	ontributing to death b	out not resulting in	the underlying o	cause give	n in Part I.	23e. Did to	bacco use cont	ribute to the	ne cause of death?
	ds,	uires signe	d by	Deafw	=	<b>,</b>		, g	11 71 Call 12				pably 4 []Unknown
	CO	law req as beer 2 shou	oiete							24a. Was a	an 24b. \	Were auto	psy findings available
	Re	The la ate ha page 2	Completed							autop: perfor 1 🗌 Yes	med?	death?	mpletion of cause of
	Division of Vital Records,	ysician: The serificate director, pag	Be	25. Was case referred to medical examiner?	Hannital .				26. Place of Death				
	of	Physi this c	.To	1 Yes 2 Namer of Death	Hospital: 1 Impatie			-	4   Nursing Hon		ence 6 Oth		y)
	on	ding th. th. : After s funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year) Inj	ury M	28c. Injury Work 1 □ Y	a` ′es 2 ∐No	od. Describe III	ow injury occurr	90	
	Visi	Attendi ar death. actor: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	jury - At home, farr tc. (Specify)	n, street, factor	y, office	2	8f. Location (S City or Town	treet and Numb	er or Rura	I Route Number,
	Ö	ital or irs afte raf Dir led in											
		To the Hospital or Attending Ph within 24 hours after death. To tha Funaraf Diractor: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best niner: On the basis o and manner st	of examination and	death occurred for investigation	at the tim i, in my op	e, date and place, a inion, death occurre	and due to the cond at the time, d	ause(s) and ma late and place, a	nner as st and due to	tated. o the cause(s)
		WSL	Σ	29b. Signature and title of certifier	lhough	MD		D - 0	0542(		Of the signed		Day, Year) D4—
		<i>&gt;</i>		30 Name and address of person who DL- Reman	3 Keine	24, 34	ype, Print)	Cal	m dun	c, Wes	mimter	MC	21157
		Sta Registr	1	31. Date filed (Month, Day, Year)  JAN 1 6	222	'ar's Signature	1	00 -					,
	DH	IMH 17 Rev 1/2	001	J/111 2 0		Ar Ar	Ligary						
						ORIC	SINAL						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Year **Physician** Colleen Erin Rigby 20 2004 Jan. 7:00 PM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Charles County Nursing & Rehab LaPlata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□ M **2**□ F Months 579**-**92-2213 Yrs. Director 36 Wash Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at anones. 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Charles LaPlata 1 ☐ Yes 為 No Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9465 May Day St. U.S.A. 20646 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XNever Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Completed by Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled None 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Philip G. Rigby. Naomi Hyndshaw Rigby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Philip G. Rigby, Sr./Father 9465 May Day St. LaPlata, MD 20646 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Resurrection Cem. 1/24/04 Clinton.MD 21. Signature of Funeral Service Licensee AREHART ECHOLS FUNERAL HOME, P.A. MO0945 P.O. Box 567 LaPlata.MD 20646 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physiclan/Medical Examiner or Attending Physician: The law requires that the death cartificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last attanding physician and Division of Vital Records, P.O. Box 68760, to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2E No 1 Yes 1 ☐ Yes 2 ☐ No No trie month after deam.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) Certification: To 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier (Check only one) Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Yeer) 04 201 225 MP 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Timothy R. Pace, MD 12070 Old Line Centre Waldorf, Maryland 32. Registrar's Signature State 2004 Registrar

			For State Registrar	1 1040	State of	Marylar	nd / Depa		t of H	ealth a	and M	fental Hyg		004	03177						
			1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of								3. Time of Death										
	Physici /Medi		Betty L	. Ruhl								January	16,	2004	5:35 p M						
	Examir		4a. Facility Name (If	not institution, g	ive street and numb	er)	-	4b. City,	Town, or	Location	of Death	·	4c. Coi	unty of Deeth							
			Anne Arundel Medical Center Annapolis						Ar	ne Arı											
ŀ	Funeral Director		5. Social Security Nu 177–24–7.	301	Sex 1 ☐ M 2 🖸 F	Age (In yrs.	last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day Oct. 29	193	9. Birth	plece (State or Foreign ntry) nsylvania						
	and wo		Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits						
	Mary -1 sho	ţ	MD	Anne Ar	rundel		Sever	na Par	rk						1 ☐ Yes 2 No						
	with the	i Direc	10e. Street and Num 6 Tyding:				10f. Zip Code 21146						10g. Citizen of What Country? USA								
936	within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28e-1 show ta Madical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Marrie 3 Widowed	Armed Force 1 Yes 2 If Yes, Give	1 Yes. 2 No If Yes. Give Year or Dates:  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Was Decedent of Hispanic Origin? (Specify Yes or Nilf Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:  dent's Usual Occupation kind of work done during most of working DO NOT use retired)			ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White										
21215-0036	hin 72 ho In "natur Medical	Completed by	(Speci	Education trade completed)						ing	16b. Kind of Business/Industry		dustry								
21	filed with Hygiene ther thai	E	12	luary (0-12)	College (1-4	01 54)		Home	emake	er			Нол	ne							
Maryland	es 1 and 2 should be of Health and Mental fitem 27 is marked or rother traumatic ever	To Be (	17. Father's Name ( John Rees		st)							e (First, Middle, e Tritt	Maiden Sur	name)							
			19a. Informant's Na Albert L					ng Address Vdings				na Park			Code)						
Baltimore,			20a. Method of Disp 1 ☐ Burial 2 5 4 ☐ Donation	Cremation 3	Removal from Sta	ate C	Place of Disponentery, crerestro Cr	natory or o	ther place	9)   1	Janu 20	ary 19,		on - City or To							
Balti	permit. Page Department of Importent: If eny injury or once.		21. Signature of Fur	_			22	Name an Barrar 195 Go	d Addres	s of Facilit & Son Ritch	Š. P				uneral Home MD 21146						
Physician /Medical Examiner  Sequentially list conditions, if any, leading to immediate cause or injury that initiated events resulting in death) Last  23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Myclody  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											Approximate Interval Between Onset and Death										
ords, P.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medical	by Physician/Medical	by Physician/Medical	by Physician/Medical	by Physician/Medical	by Physician/Medical	by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 10 Unknown Part II. Other signifi	pregnant nonths?   No	d	n 2 ∏ Feta tat time of d n	ancy Il death 3 [ leath 5 [	Ectopic pro Other (spo	ecity)	n in Part I.		23e. Did tol	bacco use c		ony Day Year ne cause of death? eably 4 □Unknown
al Record		Completed										24a. Was a autops perform	v .	b. Were auto prior to cor death? 1 🗆 Yes	psy findings available mpletion of cause of 2 No						
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referre		Hospital:				Othe			(Check only on		3150							
of	ding h. After fune	tion: To	1 Tes 25 No 1 Simpatient 2 E					28b. Time of Injury at Work?  M 1 ☐ Yes 2 ☐ No  Other: 4 ☐ Nursing Home 5 ☐ Residence 28d. Describe how in Work?													
Division	n ite	Certification:	3 Suicide 4 Homicide	6 Could not determine	d 286. Place of	Injury - At ho etc. (Specif	ome, farm, stre	et, factory	, office			28f. Location (St City or Town		imber or Rura	l Route Number,						
	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in 1	edical C	29a. Certifier (Check only one)	1 Certifying F	Physicien: To the beaminer: On the basis and manner	s of examina	wledge, death ition and/or inv	occurred a restigation,	at the time in my op	e, date an inion, dea	d place, a	and due to the ca	ause(s) and ate and plac	manner as st e, and due to	ated. the cause(s)						
)	To the within the transfer of	5	29b. Signature to	itle of certifier	mille	0		290	License	number 838	7	2	9d. Date sig	med (Month, 1 H 200	Oay, Year) H						
			30. Name and addre	ss of person who	e OWCA	of death (Item	n 23a) (Type,	Print)	Bes	tgar	1e /	2a. Av	map	olis,	ued.						
	Sta Registr	te	31. Date filed (Monti	JAN 2 1	32. Regi	istrar's Signa	iture	house	g.												

			1 - For State Registrar	State of Maryland		rtment of H		•	ene2004	03178	
	Physici		Decedent's Name (First, Middle, Last)     ALICE IRI	ENE RINGLE				2. Date of Death Month	Day Year	3. Time of Death 2:04	
	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Dear	JAN 2	0 2004 4c. County of Death	2.04	
			NATIONAL NAVĄL ME				ESDA		MONTGOM	ERY	
4	Funeral Director		5. Social Security Number  220-20-9041  Usual Residence of Decedent	7. Age (In yrs. lass	Yrs.	Months Days	If Under 24 Hrs Hours Min			place (State or Foreign intry) yland	
	yland how		10a. State 10b. County	10c. City, T	own or Loc					10d. Inside City Limits	
	Ba-f e	ecto	Maryland Anne Arur	ndel			apolis		1 ☐ Yes 🏖 █️No		
	3a or 2	Dir	130 Hearne Road, A	Apt. 711		10f. Zip Code	21401	10	g. Citizen of What Co U.S.A.	untry?	
36	d within 72 hours after death with the Maryland Jiene. I then "naturel", or Itams 23a or 28s-f ehow Ita Medical Exament must be trafffed at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3XXVidowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZXXNo If Yes, Give Year or Dates:	1	/as Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: W		
15-0036	within 72 hour ene. then "natural	Completed t	15. Decedent's Educ (Specify only highest grade	cation 1	(Give k	ent's Usual Occupa ind of work done of O NOT use retired	uring most of wo	rking	6b. Kind of Business/l	ndustry	
717	d withi	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		tail Wor			Retail		
yiand	ould be fited v Mental Hygie arkad other i	To Be C	17. Father's Name (First, Middle, Last) Arthur M. Bencho	off			18. Mother's Na Lulu D	me (First, Middle, M. Delphi	aiden Sumame)		
, Mary	S E E		19a. Informant's Name/Relationship (Type Kathy Ringle Mitc			Address (Street a			City or Town, State, Zi , MD 21401	ip Code)	
Baitimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra ance.		20a. Method of Disposition 1 ☐ Burial 255 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	omoval from State	etery, crem. Crem	ition (Name of atory or other place atory	1/2	2/2004 B	oc.Location - City or T altimore,	MD	
gair	permit. Departn Imports eny inju		21. Signature of Funeral envice License	Lillo					ylor Funer Annapolis,		
E	- 10 m		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cations that caused the death. It e cause on each line.						Approximate Interval Between Onset and Death	
	Physician /Medical Examiner		disease or condition resulting in death)	METASTATIO		AMOUS CEI	L CANCE	R			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	ce of).						
9/00,	ate be executed hysician and the burial-transit		resulting in death) Last  Due to (or as a consequence of):  d								
õ	leath certificate attending phys I for use as the	ed	IF FEMALE:	Bc. If yes, outcome of pregnancy	,		264				
O. BOX	death e atter d for u	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☒ No  9 ☐ Unknown						23d. Date of delivery  Month Day Year		
cords, P	w requires that the de been signed by the should be detached								cco use contribute to l	he cause of death?	
Leco	ea S C							24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of	
		Bec	25. Was case referred to medical examiner?					ath (Check only one)			
0	h sid	. To	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Ct			1				
DIVISION	fte and	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		8 28c. Injury at Work? M 1 □ Yes 2 □ No		28d. Describe how			
	al or Atte s after des al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical (	29a. Certifier 1 XCertifying Physic (Check only one) 2 Medical Examin	ician: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the time estigation, in my op	e, date and place inion, death occu	, and due to the cau irred at the time, date	se(s) and manner as s a and place, and due t	stated. o the cause(s)	
	To the To the Comp	Ž	29b. Signature and title of certifier	1 1		29c. License	number	290	. Date signed (Month,	Day, Year)	
			30 Name of 1		-	050		T 17.45	Jan a		
			30. Name and a fress of person who coff KEVIN K. CHUNG	CAPT MC USA	a) (Type, P	rint)		AL NAVAL M DA MD 2088	EDICAL CEN 9-5600	TER	
4	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 2 20	32. Redistrar's Signature	* 4	Land B		2000			

			For State	State of Maryland / Dep			•				
			Registrar  1. Decedent's Name (First, Middle, Last)	Ce	Tillicale of Dealif		g. No 009 001/				
	Physici	an				2. Date of Death Month	Day Year 3. Time of Death				
я	/Medi	cal	Russell F. Shea		T	January					
	Examir	ıer	4a. Facility Name (If not institution, give s.		4b. City, Town, or Location of Deat	h	4c. County of Death				
			St. Mary's Nursin  5. Social Security Number 6. Sex		Leonardtown ) If Under 1 Year   If Under 24 Hrs.	Tab. (5)	St. Mary's				
и	Funeral		1 🖼	M 2□F Yrs	Months Days Hours Min.	(Month, Day, )	9. Birthplace (State or Foreign Country)				
	Director		282-16-2774 Usual Residence of Decedent	82		Nov. 20,	1921 Ohio				
	land		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits				
	Many Fig.	ŏ	Mararal Ch. Mararal	C-145	4 L		1 Tyes 2 No				
	the 28a	Director	Maryland St. Mary' 10e. Street and Number	s Californ	10f. Zip Code	100	g. Citizen of What Country?				
	With With		44580 Elizabeth Wa	×7	20619		SA				
	be filed within 72 hours after death with the Maryland tal Hygiene. ed other than "naturel", or Items 23e or 28e-1 show event, the Mysical Exarting transitie notified at	Funeral					14. Race - American Indian,				
•	r.Her	臣	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Arres 2 □ No 1941-	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.				
ř	orsa off,	þ	3 ₩ Widowed 4 □ Divorced	If Yes, Give Year or Dates: 1945	1 ☐ Yes 2 Mo Specify:		Specify: White				
ş	2 ho	ted	15. Decedent's Educ	ation 16a Dece	edent's Usual Occupation	16	6b. Kind of Business/Industry				
2	within 7 ene. than "n	pie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) (Give life.	e kind of work done during most of wor DO NOT use retired)	rking	ŕ				
2	e filed within al Hygiene. I other than '	Completed	Clotheritary/Secondary (5-12)		k Manager		County Government				
ğ	Hygiv other	BeC	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma					
ā	should be nd Mental marked c matic eve	To B	Thomas Shea		Franki	e Bowen					
<u></u>	should ind Men ind marke umaric		19a. Informant's Name/Relationship (Typ	e, Print) 19b. Mail	ing Address (Street and Number or Ru	ral Route Number, (	City or Town, State, Zip Code)				
Ž	ath a		Thomas Shea/ Son		O Elizabeth Way,						
ā,	ーゴッニ		20a. Method of Disposition	20b. Place of Disp	osition (Name of matory or other place)	Date 20	Oc. Location - City or Town, State				
6 E	Pages nent of int: If it		1 M Burial 2 ☐ Cremation 3 ☐ Re  1 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		/22/2004 1	Timonium, Maryland				
Baltimore, Maryland 21215-0036	artm ortar injur		21. Signature of Funeral Service Can-				Funeral Home, P.A.				
e T	permit. Departr Imports any inj	Į.	Edward N. Brinsfi		2955 Hollywood Roa		=				
	- B										
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Obset and Dean								
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Expusion Table 1								
	Examiner			Due to (or as a consequence of):	6/3		B				
		-	Sequentially list conditions, b.	me							
	ed isit	ine	Sequentially list conditions, lary, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6							
	and and I-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):	Me / Neg .		WTE.				
, 60,	eath certificate be executed attending physician and for use as the burial-transit	calE		Dus to (or as a consequence of).							
189	cate ohysi the I		d.								
2	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	by Physician/Medi	tF FEMALE:				1				
POX	ath c ttenc or us	lan/	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of delivery  Month Day Year				
	e de the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5 [ 9☐ Unknown	Other (specify)		Within Day real				
ĭ	that the de ned by the a detached f	Phy				77					
vî	w requires that been signed is should be det	ρ	Part II. Other significant conditions cont	nouting to death but not resulting in the U	Inderlying cause given in Part I.		cco use contribute to the cause of death?				
2	inpe sen s	Completed		11/1/1/27	<u></u>	1 ☐ Yes	2 No 3 Probably 4 @Unknown				
Division of Vital Records,	hasbe	ple	- DENSKY?	a firstenta)	L'	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
Ľ	The ate h	mo:				performe	d? death?				
<u> </u>	ien: rtifică stor. 1	BeC	25. Was case referred to medical		26. Place of Dea	th (Check only one)	7,5700 2,510				
>	ysic is ce direc	To E	examiner? 1 ☐ Yes 2 ₺ No Ho	spitat: 1 Inpatient 2 ER/Outpatier	Oth		se 6 Other (Specify)				
0	g Ph erth eral	2	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at	28d. Describe how					
0	ndin ath. r: Aft e fun	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No						
<u>N</u>	Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, str	reet, factory, office		et and Number or Rural Route Number,				
5	afor after after I Dire	ert	4   Homicios	building, etc. (Specify)		City or Town, S	State)				
	Hospital or Attending Physicien: 44 hours alter death. Funeral Director: Alter this certifics tely filled in by the funeral director; t		29a. Certifier 1 1 Certifying Physi-	cian: Toythe best of my knowledge, deat	h occurred at the time, date and place.	and due to the caus	se(s) and manner as stated				
		edicai	(Check only 2 Nedical Examine	On the basis of examination and/or in and/manner stated.	vestigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)				
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)				
	P S P Ó		1 AVIT	lastro-MM	D 04/1/19	,	1 11 04				
Q	0	1	20. Name and address of 5	NO PURE IVI	Delay COTI		1-H-UT				
ソ	4		30. Name and address of person who com	, M.D., 24035 Three		wood M-	nv.1 and 20626				
	CA	• 0	31. Date filed (Month, Day, Year)	32. Registrar's Signature		.ywoou, Ma	Tytanu 20030				
物	Sta Registr		JAN 22		Saint "						

			For	State of M	aryland / Dep	artment of H	Health and	•	•	1. 00100		
			1 - Stete Registrar		Ce	rtificate of	Death	F	Reg. No. CUU	4 03101		
	Physici /Media		Decedent's Name (First, Middle, I     Marvel Aura	2. Date of Death Month January			Day Yee					
	Examir	er	4e. Facility Name (If not institution, g			4b. City, Town, o	or Location of Deat	h	4c. County of De	eath		
			Calvert Memoria				Frederic		Calver			
	Funeral Director		577-09-8936	. Sex 7. Ag 1 ☐ M 2 🖾 F	ge (In yrs. last birthday) 88 Yrs.	Months Days	If Under 24 Hrs Hours Min.			Birthplece (State or Foreign Country) Maryland		
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits		
	Aaryli eho	ō	Calarant		Solomons					1 □Yes 2√□No		
	289-	Director	Maryland Calvert  10e. Street and Number		DOTOMONS	10f. Zip Code			10g. Citizen of What			
	with Se or	0	11740 Asbury Circle				20688	USA	oodnay:			
	ns 2;	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (S	Specify Yes or No-		merican Indian,		
36	should be filed within 72 hours after death with the Maryland nd Menial Hygiene marked other than "naturel", or Items 23e or 28e-f ehow martic event, the Medical Exampler must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1	No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		to Rican, etc.)	Black, W Specify:	hite, etc. White		
Maryland 21215-0036	ture ture	edi	15. Decedent's		16a, Dece	dent's Usual Occup	nation		16b. Kind of Busines	viteubnles		
15	in 72	Completed	(Specify only highest of	grade completed)	(Give	kind of work done DO NOT use retire	during most of wo	rking	TOD. TAITO OF DUSKIES	samuostry		
212	d with	E o	Elementary/Secondary (0-12)	College (1-4or:	5+)	Statisticia			Telephone	Company		
פַ	e filed other vent,	0	17. Father's Name (First, Middle, La	st)	· · · · · ·		18. Mother's Nar	me (First, Middle,	Maiden Sumame)			
<u>a</u>	Suid be Mental arked o	To B	Andrew	Dudley Jackso	n		Marian	Mae Oliver	Mae Oliver			
ary	2 should and Men is marke		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Numbe	r, City or Town, State	, Zip Code)		
	1 and 2 Health a em 27 is		Joseph F. Cheseldine	/Great Nephew	P.O. E	30x 70, 380	90 Ed Brown	Road, Col	tons Point,	MD 20626		
ore C	of He		20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3	□ Bemoval from State	20b. Place of Dispo	osition (Name of matory or other place	cal	Date	20c. Location - City	or Town, State		
Ĕ	Pages ment of ent: # lt		'4 □Donation 5 □ Other (Spec	cify)	Metropolit	an Cremator	y Janua	ry 20 <sup>200</sup>	lexandria, V	irginia		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 is marke eny injury or other traumatic once.		21. Spin tu e of Funeral Service Lic	Hardene	Ma	2. Name and Addre ttingley-Ga O. Box 270,	ess of Facility ardiner Fun	eral Home.	P.A.			
7			23a. Part . Enter the disease, or co	mplications that cause	the death. Do not en					Approximate		
В	Physician		shock, or heart failure. List on Immediate Cause (Final	y one cause on each II	ne.	16	Rin.			Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)	Due te for as	a consequence of):	Intarc	TIOL			<24 his		
ija. Res	Examiner			· Coxa	nan A	rtery i	tion Disease			antimoron		
1 A	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	109						
	acute ind trans	Examiner	that initiated events	с								
760,	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as	a consequence ot):							
8/6	m % 0	dicai	,	d								
29 X	the death certifically the attending phoche iched for use as the	Physician/Medi	IF FEMALE:	00-14								
ROX	attenc for us	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	у		23d. Date of d Month	elivery Day Year		
o.	by the a	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊡Pregnant at 9⊡ Unknown	time of death 5	Other (specify)						
2	res that the igned by be detact	F.	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tot						bacco use contribute	acco use contribute to the cause of death?		
ecords,	law requires that as been signed b 2 should be deta	d by							,	,		
Ö	w requir been si should I	Completed						040 1400				
ĕ	0 - 0	du						24a. Was a autops perform	y prior to	autopsy findings available completion of cause of		
	i <b>ician:</b> Th certificate rector, pag	e Co	25. Was case referred to medical	-				1 ☐ Yes	2 ☑ No 1 ☐ Ye	s 2 No		
Vital		o Be	examiner?	Hospital:	26. Place of Dea lospital: 1 ☐ Inpatient 2 Z ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hi							
	Phys r this eral dir	$\vdash$	27. Manner of Death	28a. Date of Inju	ry 28b. Time of	IL SEL DOA	3 DOA 4 Nuising Hom		ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
0	ding th. th. After funer	ti or	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Da	y Yeer) Injury		rk? Yes 2 □ No					
DIVISION	of or Attending after death. Director: After I in by the fune	Certification;	3 Suicide 6 Could not determine		ury - At home, tarm, str c. (Specify)	eet, factory, office		28t. Location (St City or Town	treet and Number or I n. State)	Ru <i>ral Route Number</i> ,		
_	To the Hospitel or within 24 hours after To the Funeral Direction plately filled in b		29a. Certifier Certifying F	Physician: To the best	of my knowledge, deat!	h occurred at the tin	ne, date and place	, and due to the ca	ause(s) and manner a	as stated.		
	the Ho in 24 the Fu	edical	(Check only 2 ☐ Medical Excone)	eminer: On the basis of and manner sta	examination and/or in	vestigation, in my o	pinion, death occu	rred at the time, d	ate and place, and du	e to the cause(s)		
	With it	E	29b. Signature vid title of certifier			29c. Licens	e number	2	9d. Date signed (Mor	nth, Day, Year)		
11-14	100		Mallerin	MA		DA	5862	2 1	Vm 19 2	004		
)).	510		30. Name and address of person wh	o completed cause of d	eath (Item 23a) (Type.	Print)	and all the second		11/6	/		
_			Guylin Sinte	10000	110 Has	Rd 241	2.20 0	11-1-19	Units No	0 20016		
	Sta Registr		31. Date filed (Month, Day, Year)	0 2004 Regist	ar's Signature	Shorte						

		Registrar		Ce	rtificate o	r Deatr			eg. No.		, 0010
Physician		1. Decedent's Name (First, Middle, Last						<ol><li>Date of Dear Month</li></ol>	th Day	Year	
/Medical	1	Robert Blair Swan			T			JANUARY		2004	05:49 a
Examiner	r	ta. Fecility Name (If not institution, give St. Mary's Hospit.			4b. City, Town		of Death			County of De t. Mar	
Funeral		5. Social Security Number 6. Se		s. last birthday)	If Under 1 Yea	ar If Unde	r 24 Hrs.	8. Date of Birth (Month, Day)			
Director			M 2□F 78	Yrs.	Months Day	rs Hours		Month, Day, August 19			irthplace (State or Fore Country) 191and
1000	-	Usuel Residence of Decedent	100	0:h . T							1
ehov Ed et		10a. State 10b. County		City, Town or Lo							10d. Inside City Lim
28a-1	601	Maryland St. Mary	'S	Valley			<del>.</del>		0 0'11-	en of What C	
D Leg	5	19198 Oak Farm La	ne		10f. Zip Code	20692			og. Citizi	USA	country?
than "natural", or items 23s or 28s-f show its Middel Examiner result be notified at simple ted by Fineral Director	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of	f Hispanic O	rigin? (Spec	of Yes or No-	14		nerican Indian,
P. P. P. P. P. P. P. P. P. P. P. P. P. P	2	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No		If Yes, specify Cu	uban, Mexica	in, Puerto F	lican, etc.)		Black, Wh	
English A	à	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 N	lo <i>Specit</i> y	<i>/</i> :			Specify:	White
ygiene.  ner than "natural", o  it, the Medical Exam  Completed by	ere	15. Decedent's Edu (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occ	e during mo:	st of workin	g	16b. Kind	d of Busines	s/Industry
than	E	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DD NOT u</i> se reti ne <b>r</b>	red)			C.	1	C to
Hygie ther in	3	17. Father's Name (First, Middle, Last)		OWI	ilet	18. Moth	er's Name	(First, Middle, I			Store
Mental H srked oth stic even	ă	Benjamin Gorman S	wann					Guyther			
mar mar	-	19a. Informant's Name/Relationship (T)		19b. Maifi	ng Address (Stre					Town, State,	Zip Code)
alth a		Nancy A. Haynie /	Daughter	16384	4 Piney	Point	Road	Piney I	oint	t, MD	20674
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow eny injury or other traumatic event, the Middical Examinat must be notified at once.  To Be Completed by Funeral Director	1	20a. Method of Disposition 1XD Burial 2 ☐ Cremation 3 ☐F	20b.	. Place of Dispo	osition (Name of matory or other p	elace)	Da	ite :	20c. Loc	ation - City o	r Town, State
ant: h		'4 □ Donation 5 □ Other (Specify)					01/10/	2004 \	/a11e	ey Lee	, Maryland
Departi Import eny in	1	21. Signature of Funeral Service Licens	99	22	2. Name and Add	fress of Facil	<sup>ity</sup> Matti	ngley-Gar	dine	Funera	al Home, P.A.
10599	1	Fight In	-4+1					town, Mar	-	20650	
<u> </u>	j	23a. Part f. Enter the disease, or composhock, or heart failure. List only o	ne cause on each line.		1			-			Approximate Interval Between Onset and Death
nysician	- 1	Immediate Cause (Final disease or condition resulting in death)	a	DIVET	5:12-/	DNER	Inn	NIL	/		72 /2/
Medical	,			100		100	- 10				
aminer			Due to (or as a cons	equence of):	10~ /		- 10				12013
	5	Sequentially list conditions,	b. Due to (or as a conse								
le le	in the last	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b								
le le	Examine	any leading to immediate	b	эдиепсе об.							
Je Je	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a conse	эдиепсе об.							
g physicien and as the burial-transit	uicai Examine	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Oue to (or as a conse	equence of):		211					
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			1 - For State Registrar	State of M	<b>laryla</b> r	nd / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth a	and M	lental Hyg	iene	200	4 0318
37	Physic	ian	1. Decedent's Name (First, Middle, Last	)		· · · · · · · · · · · · · · · · · · ·					2. Date of Deat Month	h Day	Year	3. Time of Death
1	/Medi		RALSEY B. SCOFIE								JANUARY	16,	2004	2355 <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give WILLIAM HILL MANC	R	,		EA	STON					ounty of Dea	ith
	Funeral Director		5. Social Security Number  6. Se  006-18-5718  Usual Residence of Decedent	X 7. A	81	. last birthday) Yrs.	If Under Months	Days	If Under a	Min.	8. Date of Birth (Month, Day, MAR 22	1 922	9. Bii	thplace (State or Foreigr owntry) NECTICUT
	show		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside City Limits
	he Ma	ecto	MD TALBO	T	S	T. MIC					1			1 ☐ Yes 2X No
	with t	5	10e. Street and Number 7130 PEA NECK RD.				10f. Zip	1663			10	-	in of What C	ountry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Eventine Innual Leurstling and other traumatic event, the Medical Eventine Innual Leurstling and	by Funeral Director	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces Market Yes 2 If Yes, Give Year or Dates	? ] No		Was Deced	dent of Hi cify Cuba	n, Mexican	gin? (Spo , Puerto	ecify Yes or No- Rican, etc.)	14	Race - Am Black, Whi	erican Indian, te, etc. HITE
21215-0036	ithin 72 ho ie. isn "natur i.Me ilc.	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	ication le completed) College (1-4or	5+)	16a. Deced (Give life.	ient's Usua kind of woi DO NOT us	rk done a	lurina most	of work	ing	16b. Kind	of Business	Vindustry
121	Hygier Hygier ther th		12 17. Father's Name (First, Middle, Last)	4		MAN	UFACT	URIN	G REP		e (First, Middle, N		EET ME	TAL
Maryland	1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other then thar traumatic event, It a Me	To Be	RALSEY B. SCOFIE	LD SR.							JOHNSTO		imame)	
lary	2 should and Men and Men Is marke		19a. Informant's Name/Relationship (T)			19b. Mailir	g Address	(Street a			al Route Number,		own, State,	Zip Code)
	1 and Health em 27 thar tr		ELIZABETH P. SCOFT  20a. Method of Disposition	ELD/WIFE	20h F	7130 Place of Dispo	A-3-A-6-Television		K RD.		MICHAEI			
nor			1 ☐ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)		•	cemetery, cren	natory or of	ther place						Town, State
Baltimore,	_ 든 판 글 .		21. Signature of Funeral Service Licens		Опа	22	. Name an	d Addres	s of Facility	v	8-2004			
m	Depa Impo any ir		JOHN R.	MERCI	ERO		ELLOW	HAR	${f RISON}$	ST REIN	EASTON,	MD 2	INERAL 21601	HOME PA
197	Physician /Medical		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	line.	mon	1 CI	e of dying	g, such as d	cardiac c	or respiratory arre	st,		Approximate Interval Between Onset and Death ZWKS
8760,	cate be executed bysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as										
P.O. Box 68	The law requires that the death centificate be executed te has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 🗌 Feta	il death 3	Ectopic pre					230	f. Date of del Month	ivery Day Year
	quires that in signed b uld be deta	by	Part II. Other significant conditions con	ntributing to death	but not res	ulting in the ur	iderlying ca	ause give	n in Part I.					the cause of death?
of Vital Records,	. a .T	Completed	Renal insuf	heien	ay						24a. Was an autopsy perform		24b. Were au prior to death? 1 \(\sum \text{Yes}\)	Itopsy findings available completion of cause of
Vita Vita	siclan certifi rector	Be	25. Was case referred to medical examiner?	lospital:				Othe			Check onl one			
on of	ding h. After fune	tion: To	27. Manner of Death Natural 5 Pending	1 ∐ Inpati 28a. Date of Inj (Month, Da	ury	28b. Time of Injury	-	Bc. Injury Work	4 Lynur	2	ne 5 🗌 Resider 28d. Describe hov			cify)
Division	spital or Attending ours after death. Neral Director: After filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At ho tc. (Specif	ome, farm, stre					28f. Location (Stre City or Town,		lumber or Ru	iral Route Number,
	Fu P	edical C	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Exami	sician: To the best ner: On the basis of and manner s	ot examina	owledge, death ation and/or inv	occurred a estigation,	at the time in my opi	e, date and inion, death	place, a occurre	and due to the cau ad at the time, dat	ise s an e and pla	d manner as ace, and due	stated. to the cause(s)
)	To the verthin 2 To the complete	W	29b. Signature and title of certifier	u all	h	wO	29c.	License	Number 2	84	29	2	igned (Month	h, Day, Year)
			30. Name and address of person who co	empleted cause of	death (Iten	n 23a) (Type [	Print)	ash	engl	fon	St E			MD 26601
Ī	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 0 2	32. Regist	car's Signa	ature	and o		U					

DHMH 17 Rev 1/2001

WILLIAM SCOFIELD

				tate of Maryland	l / Departmen	t of Health and N	lental Hyg	iene	L 03183
					Certificat	e of Death		eg. No.	7 00100
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) HECTOR BRICE	BOUTE			2. Dete of Deat	7 - 2004	3. Time of Death 4 0720am
-	Examir	_	4a Facility Neme (If not institution, give stre	et end number)	TON	4b. City, Town, or L	ocation of Death	4c. County of E	JNE JNE
	Funeral Director		5. Social Security Number 6. Sex 15-18-4724	7. Age (In yrs. Ia	st birthday) If Under Months	1 Year If Under 24 Hrs. Deys Hours Min.	8. Date of Birth (Month, Dey,	Year) 9. 3-1913	Birthplace (State or Foreign Country)
	within 72 hours after deeth with the Menyland ene. then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at	tor	Usuet Residence of Decedent  10a. Stete 10b. County  AROLII	VE FE	Town or Location DERAL	SBURG			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-1 show any lojury or other traumatic event, the Medical Evandret must be notified at once.	Funeral Director	10e. Street end Number	ON ROAD	10f. Zip	Code 211037	1	Og. Citizen of Whet	Country?
	items 2	unera	7	Was Decedent Ever in U,S Armed Forces? 1 Myes 2 □ No	i. 13. Was Deced	lent of Hispanic Origin? (Sp cify Cuben, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indien, Vhite, etc.
0020	ural', or	þ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 195	1 Yes			Specify:	NHITE
21215-002	thin 72 h e. en *natu	Completed	15. Decedent's Educati (Specify only highest grede co		16a. Decedent's Usua (Give kind of wo life. DO NOT us	rk done durina most of worl	ring	16b. Kind of Busine	NOTTVE
	filed wi Hygien fither th	Con	17. Father's Name (First, Middle, Last)	O	HUIOF	18. Mother's Nam	e (First, Middle, M	· ·	1101110
Maryland	should be nd Mental marked o	To Be	FRED SCOTT			LENA	WILS	on	
Man	and 2 sho saith and I n 27 is me		19a. Informant's Name/Relationship (Type, MARY SUE SCOTT) W.	Print) ) I F E	19b. Meiting Address	(Street and Number or Ru	el Route Number AD FED	City or Town, Star	te, zip Code) Zi 632 BURGMO
more,	Peges 1 ar nent of Hea int: If Item 2		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Rem	CO	ace of Disposition (Nametery, cremetory or o	ne of ther plece)	Date	20c. Location - City	
altim	permit. Peg Department Important: I any Injury o		4 ☐ Donation 5 ☐ Other (Specify)  21. Sign cut of Funeral Service Licensee	CAI	22. Name ar	d Address of Facility	130107	DOVER	, UK
<u></u>	Dema Impo any li		Hab		3115.1	MAINST.FE	DERAW	BURG, 11	
and f	Physician		23a. Pert1. Enter the diseese, or complicate shock, or heart failure. List only one of	ions that caused the death. ause on eech line.	Do not enter the mod	e of dying, such as cardiac	or respiratory erre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Finat disease or condition resulting in death)	Conges	stive 1	reart R	ailure		weeks
	P #	Iner		Due to (or	as a consequence of):	pa thy			4620
<u>,</u>	be executed sician end burial-trensit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying		es e consequenç <del>a o</del>	0 2 200	dise	700	
κ 68760,	rtificete be ng physicia s es the bur	Medical	Ceuse (Disease or injury that initieted events resulting in deeth) Last		on ary	The eld	Gise	doc	YERKT
P.O. Box 68	death ce e ettendi d for use	Physician/Medi	Part II. Other significant conditions contrib	uting to death but not resul	ting in the underlying o	ause given in Part I.	23b. Did to	becco use contrib	oute to the cause of death?
	that the ned by the e deteche	by Phys					1 🗆 Y	os 2) No 30	Probably 4 Unknown
scords	The law requires that the death certificate ete hes been signed by the ettending physpege 2 should be deteched for use es the	Completed t					24a. Was e perforr		4b. Were autopsy findings available prior to completion of cause of death?
a R	: The la						+□ Ye	-,	1 ☐ Yes 2 ☐ No
Ĕ	lclan certifi recto	Be	25. Was case referred to medical examiner?	oital:		(Othor: W	th (Check only on		2
n of	Attending Physician: or death. octor: After this certific by the funeral director,	lon: To	27. Menner of Deeth	1 inpatient 2 is		PA 4 L∄ Nursing H Rc. Injury et Work? 1 ☐ Yes 2 ☐ No		ence 6 □Other (5 ow injury occurred	Бреспу)
Division of Vital Records,	or Attendated after death Director: #	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, factor		28f. Location (St City or Town	reet and Number on, Stete)	r Rural Route Number,
_	To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physicompletely filled in by the funeral director, page 2 should be deteched for use as the	edical C	29a. Certifier (Check only one)  Certifying Physicial Examiner:	an: To the best of my know On the basis of examination and manner steted.	rtedge, death occurred on and/or investigation	at the time, date and place, , in my opinion, death occur	end due to the ca red at the time, da	ause(s) and manne ate and place, and	or es stated. due to the cause(s)
	Vithir To th	M	29b. Signeture and title of certifier	Wei	11/	. License number		9d. Date signed (M	1
			30. Name end eddress of person who comp	leted cause of deeth (Item	23e) (Type, Print)	004753	4	1/17	104
		d	920 Market	St ilin		1 21629			
100	CA	ate	31. Dete filed (Month, Day, Year)	32. Registrer's Signati	ura				

DHMH 16 Rev 6/95

State Registrar

			1 - For State Registrer	State of Marylar	nd / Depa		ealth and M	Reg. N	e2004	03184
	Physici	an	1. Decedent's Name (First, Middle, Last)	5 mi	th				ay Year	3. Time of Death
>	/Medic Examir		4a. Facility Name (It not institution, give: Dennett Roc	street and number)		4b. City, Town, or I	Location of Death	January 19	c. County of Death	1
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. ] M 2熨F	Vrc	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Feb. 1, 19		nplace (State or Foreign untry) nington, DC
	tryland show	_	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation		-		10d. Inside City Limits
	the Ma	Director	DC		· · ·	Washir	ngton	100.0	itizen of What Co	1 ☑ Yes 2 ☐ No
	h with	ai Dir	647 Condon Terra	ace SE			0032	109. 0	USA	andy:
	tems (	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of His f Yes, specify Cuban		cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-1 show te Madical Exemirer must be naillied at	۵	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No				lack
215-	d within 72 ho jiene. r then "natu ine Madical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	lent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of working	ng 16b.	Kind of Business/I	ndustry
212	filed with Hygiene. Ither ther	Com	12th	College (1-401 5+)		Hostess			Hospit	:a1
Maryland	e d la b	Be	17. Father's Name (First, Middle, Last)		Uatab			(First, Middle, Maide	,	and over Monale
ary!	A P E	은	James  19a. Informant's Name/Relationship (Ty	rpe, Print)	Hatche 19b. Mailir		Eleanor ad Number or Rura	I Route Number, City		taday-Mack ip Code)
	1 and 2 : Health ar tem 27 Is		Jacquelyne Hatche:		A STATE OF THE PARTY OF THE PAR			02. Washir	ngton, DO	20019
Baltimore,	of Hir		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	1 ,	Place of Dispo cemetery, crem	sition (Name of natory or other place)	) D	ate 20c. I	_ocation - City or 1	own, State
Ħ			<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licensia</li> </ul>			ematory . Name and Address		/2004 Mo tewart Fur	reantown	
å	permit. Departr Importe any nit		> Blown H.	Marian		2 S. Secon				ie
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the deat ne cause on each line.	h. Do not ent	er the mode of dying,	, such as cardiac o	respiratory arrest,		Approximate Interval Between Onset and Death
68760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).  Due to (or as a consequence).  Due to (or as a consequence).	eus) ve uence of):	- Coxdion	osculor	diseese		loyens
.O. Box	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3□	Ectopic pregnancy Other (specity)			23d. Date of deliv Month	very Day Year
rds, P	w requires that been signed to should be det	þ	Part II. Other significant conditions con Diobets We	ntributing to death but not res	ulting in the ur	nderlying cause given	in Part I.			the cause of death?
Reco	The law requate has been page 2 shoul	Completed	enoxic en	copha lo put	hy			24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
/ita		Bec	25. Was case referred to medical examiner?	I to b			26. Place of Death		Y.I	
Division of Vital Records,	ng Phys fter this meral die	lon: To	27. Manner of Death 1 Natural 5 Pending	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury a Work?	at 2	ne 5 🗔 Residence 8d. Describe how inju		(fy)
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre			8f. Location (Street a City or Town, Stat		al Route Number,
	e Hospite 124 hours e Funerel letely filled	edical C	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Exemination	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time estigation, in my opin	, date and place, a nion, death occurre	nd due to the cause(s d at the time, date an	s) and manner as s d place, and due t	stated. o the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	Plds.	_ W	29c. License			ate signed (Month,	
7			30. Name and address of person who co	empleted cause of death (Item		Print)	0431.	59 Jan lent M	wary 15,	2007
			Walter K Nai	emann MD	POB	ox 247	. Accia	ent M	D215	20
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 0 2	32. Registrar's Signa	H. L	Corelle &				

			1 - For State Registrar	State of Marylan	d / Depa			Mental Hygie		03185
	Physici	an	1. Decedent's Name (First, Middle, Last, Richard Vincer					2. Date of Death January	<sup>Day</sup> 7,200	3. Time of Death 8:00 Pm
1	/Medio Examir		4a. Facility Name (If not institution, give 1030 South Riv	street and number)			or Location of Death Water		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Set 0 97 - 28 - 5458	7. Age ( <i>in yrs.</i> )	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth June 21	9. Bir 9. 1932 N eV	thplece (State or Foreign Quintry) or k
	72 hours after death with the Maryland natural', or items 23a or 28a-f ehow dical Examirar must be redified at	ector	10a. State 10b. County Maryland Anne A		r, Town or Lo Ldgewa	ter				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with t	ral Dir	109. Street and Number 1030 South Rive	er Landing		10f. Zip Code 2 1 (	037	10g.	. Citizen of What Co USA	ountry?
9600	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or flems 23s or 28s-f show event, Its Medical Examirar must be redified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Amed Forces? 1 ☐ Yes 2 ☐ No 1 9 5 If Yes, Give Year or Dates:	L L	Vas Decedent of H f Yes, specify Cubi	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify White	e, etc.
Maryland 21215-0036	e filed within 72 hall Hygiene. Other than "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)		ent's Usual Occup kind of work done OO NOT use retired 'Sician	eation during most of work 1)		Nind of Business	Industry
yland 2	should be filed nd Mental Hygid marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last) Vincent Ralph					e (First, Middle, Maid Sullivar	den Sumame)	
, Mar	and 2 sho ealth and m 27 is my nar trauma		19a. Informant's Name/Relationship (Ty, Marianne H. Sma				and Number or Rur River L	al Route Number, Ci anding , I	ity or Town, State, 2 Edgewate	(r, Md.2103
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic events.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Eungral Service Licenses	emoval from State Ka1	as Cr	ention (Name of patery or other place emator)	1-1	8-04 Ed	Location - City or gewater	, Md.
Ba	Depa Impo any in		The state of the s		1	Name and Address	0.0	orge P. land Rd.	Kalas F	uneral Hor
,	Physician /Medical Examiner		23a Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	Do not ente	r the mode of dyin	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
		Examiner	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	cal	resulting in death) Last	Due to (or as a consequ	ence of):					
		Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of decent	déath 3 □6	Ectopic pregnancy Other (specify)			23d. Date of deliment	very Day Year
ords, P	res t igne be d	þ	Part II. Other significant conditions con	tributing to death but not resul	ting in the und	derlying cause give	en in Part I.		_	the cause of death?
		Completed						24a. Was an autopsy performed 1 Yes 2 2 3	prior to c	opsy findings available ompletion of cause of
Vital	Physiclan: this certific	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3C DOA Othe	26. Place of Death			
Division of	Attanding Phy ir death. ector: After thii by the funeral of	<b>⊢</b> }	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	00 0 1 111	28b. Time of Injury	28c. Injury Work	4 Li Nursing Hor	ne 5 Residence 28d. Describe how in		fy)
Divis	ital or Attand irs after death ral Director; led in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree	et, factory, office	4	28f. Location (Street City or Town, Sta	and Number or Rui ate)	al Route Number,
	To the Hospital of within 24 hours at To the Funaral D completely filled in	Medical	one)	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or inve	istigation, in my op	inion, death occurre	and due to the cause and at the time, date a	(s) and manner as and place, and due to	stated. o the cause(s)
	T with		29b. Signature and title of certifier	illy and.		29c. License	Number 838	29d. 0	Pate signed (Month,	Day, Year)
	-01		30. Name and address of person who con STUANT E. Se 31. Date filed (Month, Day, Year)	elonick, m	.0.	100 Bes	tgate 1	Rd. Auv	rapolisi	Md.
	Stat Registra	~	JAN 2 1 20	32. Pagistrar's Signatu	K A	and s				

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 04 **Physician** Baby Boy Sheffield 0215 /Medical 4h. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death WICOMICO Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□ F Yrs Director **22** January 10,2004 Maryland n/a Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours ofter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Items 23e or 28e-f show finy Injury or other traumstic event, if a Medical Examinal must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Salisbury T10f. Zip Code 1⊠ Yas 2 No Director Maryland 10e. Street and Number Wicomico 10g. Citizen of What Country? 669 Fitzwater St. #1 21801 USA Funeral 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 1X Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Tia Sheffield ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tai Sheffield/mother 669 Fitzwater St., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 [XCremation 3 ☐ Removal from State Salisbury Crematory 1/16/04 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licensee 501 Snow Hill Rd., Salisbury, MD 21804 CFSP Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Prematurity 82 min /Medical Immediate Cause (Final Severe disease or condition resulting in death) Examiner Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Sa for use a signed by the e 23b. Did tobacco use pontribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Completed hes 12 Yes 2□ No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

Division of Vital Records,

213-11-9221

Hospital or Attending Physicien: efter death. Director: Aft within 24 hours e To the Funeral C completely filled To the

1 Contilying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the nause(s) and namer as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie (Check only 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 1-10-04

1) 0059822 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle URbra

milford St. 31. Date filed (Month, Day, Year)

JAN 16 2004

Suite. 307 32. Registrar's Signature

Salisbury, MD.

edical

State

Registrar

			1 - For State Registrar		State of N	arylan	d / Depa	artmen rtificat	t of H	ealth a	and M		iene 2	001	. 03 (	) n
B	Physici /Medi		Decedent's Name (First, Middle SAAMA NAZ		•	SMITH	T					2. Date of Dea Month January	Day	Year /	3. Time of Death 5:55pm	м
	Examir		4a. Facility Name (If not institution Washington Adv			r)		4b. City, Tako		Location o	of Death	Januar y	4c. County	of Deat	1	
tig .	Funeral Director		5. Social Security Number  579-19-0747  Usual Residence of Decedent	6. Se	x 7. A	Age (In yrs. 65	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day July 25			nplace (State or Forei untry) Pria	gn
	Maryland a-f show	tor	10a. State 10b. County Md. Prince		orges		y, Town or Lo								10d. Inside City Limit	
	ith with the 23s or 28s	Funeral Director	10e. Street and Number 5403 16th Ave	#20	2			10f. Zip	Code 782		···········		Og. Citizen of N Liberia		untry?	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f show other traumatic event. I'm Medical Evaninat must be invitited at	þ	11. Marital Status  1 Never Married 2 X Mai 3 Widowed 4 Divorced		12. Was Deceder Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	;? <b>X</b> No		Was Deced f Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	Blac	e - Americk, White		
21215-0036	d within 72 ho piene. r then "natu Ira Medical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)			r 5+)	(Give life. L	lent's Usua kind of wor DO NOT us Enfo	k done d se retired)	uring most		ng	16b. Kind of B		ndustry	
Maryland ?	should be fited and Mental Hygiet marked other umatic event.	To Be C	17. Father's Name (First, Middle, Nazally Mulba	h						18. Mothe	rs Name	(First, Middle, M betee	Aaiden Suman	18)		
Baltimore, Mar	Pages 1 and 2 sh nent of Health and int: If Item 27 Is rr iry or other traum		19a. Informant's Name/Relation:  Kolu M. Smith/ 20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (3	Wif 3□F	e Removal from State	CE	121 37127	ne St sition (Nam	., W	orche		ate	1604 20c. Location -	City or T		
Balti	permit. Pages. Department of I Important: If Ite any injury or of		21. Signature of Funeral Service	1	Chen	4si		. Name and			JC	hnson &				
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8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burlat-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or a	100	3/14	101	MA MA	TO 9	519 F	PROST	ATE			
P.O. Box 6	the death certific. by the attending places of the as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 🗌	Ectopic pre Other (spe					23d. Date Mor		ery Day Year	
Records, P	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditi	ons con	tributing to death	but not resu	Iting in the un	derlying ca	use giver	n in Part I.		23e. Did tob	/		he cause of death?	1
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Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death, To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To Be	examiner?  1   Yes   2   No  27. Manner of Death  1   Natural   5   Pendir 2   Accident investi 3   Suicide   6   Could	g gation	lospital: 1 V npat 28a. Date of Inj (Month, D.	ury	ER/Outpatient 28b. Time of Injury		Other	4 □ Nur	sing Hon	(Check only one ne 5 ☐ Resider 8d. Describe how	nce 6 ☐Othe		(y)	
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	To the Hospital within 24 hours a To the Funeral completely filled	Medicai	29a. Certifier (Check only one)  1 ☑ Certifyir 2 ☐ Medical 29b. Signature and title of certifie	CAMITUI	sician: To the besi ner: On the basis of and manner s	or examinati	vledge, death ion and/or inv	estigation,	t the time in my opii	nion, death	place, a occurre	d at the time, da	te and place, a	nd due t	the cause(s)	
2	2 3 6 8		30. Name and address of person	V.	mpleted cause of	death_litem	23a) (Type. F	Primit) N		24	59	3 6	d. Date signed	O L	Lay, rear)	
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			1 - For State Registrar	* * * * * * * * * * * * * * * * * * *	/aryland / D	-	ment of I			,	Reg. No. 4 U U	4 03188
	Physici	an	1. Decedent's Name (First, Middle   LCMAEL	6, Lasi) SCOTTE	7.)					2. Date of Dea	Day Yes	3. Time of Death
-	/Medic	al	4a. Facility Name (If not institution		·	46	b. City, Town,	or Location	of Death	JAN	4c. County of D	
	Examin	ier	Mercy Medical C	-	,		Baltim					
	Funeral		5. Social Security Number		Age (In yrs. last birth	M	Under 1 Year		24 Hrs. Min.	8. Date of Birt (Month, Day	h y, Year) 9.1	Birthplace (State or Foreign Country)
	Director		215-88-6775	TALIM ZLIF	31 Y	rs.				June 18		ryland
	lend ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location	ion					10d. Inside City Limits
	Many	į	Maryland Freder	ick	Frederi	ck						1 ☐ Yes 2 📉 No
	deeth with the Maryler eme 23a or 28e-f ehow ir must be coulded at	Director	10e. Street and Number			1	10f. Zip Code				10g. Citizen of What	Country?
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36	after or It	by Funeral I	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	If Yes, Give 1	s? ⊒No		S Decedent of less, specify Cub			ify Yes or No- ican, etc.)	14. Hace - A Black, W Specify:	merican Indian, hite, etc.
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Mai	is 1 and 2 should of Health and Mer Item 27 is marks other treumatic		19a. Informant's Name/Relations Jennifer Scotte		1.11	-					or, City or Town, State	
	tem 2		20a. Method of Disposition	,	20b. Place of D	Dispositio		1	Da		20c. Location - City	
Ë			1 ☑ Burial 2 ☐ Cremation  '4 ☐ Donation   5 ☐ Other (S		Θ .			. 1	1-10-	2004 F	Brentwood,	Maryl and
Baltimore,	permit. Pege Department Importent: if any injury o		21. Signature of Funeral Service	Ucens le		22. Na	ame and Addre	ess of Facilit	∀Fort	Lincol	n Funeral	Home
<u>m</u>	\$0 E E 9		Hant	Dollen							wood, MD	20722
	Pnysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that cause only one cause on each	line.	1	ne mode of dyi	ng, such as	cardiac or	respiratory ar	rest,	Approximate Interval Between Onset and Death
1	/Medical Examiner		rosumy ar county	Due to (or	a consequence of	):						C
		9	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a consequence of	):						
	cete be executed physicien end the burial-transit	Examine	Cause (Disease of injury that initiated events	G								3
ó,	e exectence len er		resulting in death) Last	Due to (or a	as a consequence of	):						
8760,	physic physic the b	dicai		d						·	-	
Box 6	eth certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ne of pregnancy 2 Fetal death at time of death		opic pregnanc	y			23d. Date of o	delivery Day Year
0	by the detected	ysk	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		50.0						
Records, P.	luires thet n signed b	þ	Part II. Other significant condition	ons contributing to death	but not resulting in t	he under	rlying cause gi	ven in Part I.				to the cause of death?  Probably 4 Honknown
00	aw requir is been s 2 should	Completed								24a. Was a	an 24b. Were	autopsy findings available
Re	The I	mo								perfor	med? death	
Vital		Bec	25. Was case referred to medica examiner?	/	<u> </u>				of Death	Check only or		
of V	Physic this co	၉	1 ☐ Yes 2 ☐ Wo	Hospital: 1 📑 Inpa	<del></del>		JU DON				ence 6 Other (S)	oecity)
ono	ding i h. After funer	tlon	27. Manner of Death 1 ☐ Natural 5 ☐ Pendir 2 ☐ Accident investi		njury 28b. Tir Day Year) 1nje	ury	28c. Inju Wo M 1	ryat rk?  Yes 2.∐		id. Describe n	ow injury occurred	
Division	al or Attend s after death il Director: A id in by the f	Certification;	3 Suicide 6 Could 4 Homicide determ	inad 286. Place of I	njury - At home, fam etc. (Specify)	n, street,	factory, office		28	If. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	To the Hospital or vithin 24 hours after within 24 hours after To the Funeral Direction completely filled in b	edical (	29a. Certifier 1 certifyir (Check only one) 2 Medical	g Physician. To the best Examiner: On the basis and manner:	of examination and/	Jeath out or investi	curred at the fi	ne, date an opinion, dea	d place, and th occurred	d due to the c d at the time, d	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To the within 2. To the complet	×	29b. Signature and title of certifie	Cota n	0		29c. Licens	number	34	2	29d. Date signed (Mo	nth, Day, Year) 200 H
	10)		30. Name and address of person	who completed cause of	death (Item 23a) (T	ype, Print	WL P	LACE	B	ATTINO	RE MD	21201
1	Sta Registr		31. Date filed (Month, Day, Year)	2. Regis	strar's Signature	arle						

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:00 P M 2004 WARDELL SULLIVAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHEVERLY PRINCE GEORGE'S PRINCE GEORGES HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5 26 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1⊠M 2□F 55 WASHINGTON, DC 1948 Director 578-64**-**2557 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1X Yes 2 No Directo PRINCE GEORGE'S LANDOVER HILLS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A 3809 64th AVENUE APT 102 20784 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married BLACK 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE ENVIROMENTAL SERVICES 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARION KEGLER THOMAS SULLIVAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 4914 1st STREET N.W. WASHINGTON, DC 20011 19a. Informant's Name/Relationship (Type, Print) RENAY D. SULLIVAN/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of It
Important: If Ite
any injury or of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □Donation 5 □Other (Specify) 1-13-2004 LANDOVER, MARYLAND HARMONY CEMETERY 21. Signature of Funeral Service/Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVEK ROAD LANDOVER, MARYLAND 20785 archa 23a. Part1. Enter the dis-use, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as # **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-transit Examl Due 19 of as a consequence of) Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Fctopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 20 3 Probably 4 □Unknown 1 🗌 Yes No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Tes 2 No 2 ER/Outpatient npatient Medical Certification: To 3 DOA (Month, Day Year) 27. Manner of eath 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P30318 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES CATAVENIS M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 JAN 1 4 2004 32. Registrar's Signatur State Registrar

DHMH 17 Rev 1/2001

Hospital or Attending Physician: The law requires that the death certificate be executed

After

ithin 24 hours after death o the Funeral Director:

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: if Item 27 is marked other then "natural", or Item

Maryland 21215-0036

Baltimore.

				<b>State of Marylan</b>						ble.	
			1 - State Ragistrar				te of Death	Re	g. No.	04	03191
	Physici		1. Decedent's Name (First, Middle, Last Wesley Albert S					2. Date of Deat Month	Day	Year 2004	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City	, Town, or Location of Death	J	4c. County	of Deeth	
			Doctor's Communit				nham	T	Princ	ce Geo	
E	Funeral Director		263-60-4310	7. Age (In yrs. II M 2□F 68	ast birthday) Yrs.		r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, April 10		9. Birthplac Country Flori	ce (State or Foreign r) da
	ow i		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d	I. Inside City Limits
	a-f sh	ctor	Maryland Prince G	George's G	reenbe	1t					1 XYes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zi	p Code	10	g. Citizen of V	Vhat Country	1?
	s 23a	eral	107 White Birch Co		C 42.3		20770		U.S.A.	e - American	Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show appring yor other traumatic svent, the Medical Exempter must be notified at ODGE.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces?  1 ⊠Yes 2 □ No 195  If Yes, Give Year or Dates: 1970	. / –	was Dece f Yes, spe 1  Yes	ident of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 No Specify:	Rican, etc.)		k, White, etc	C.
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121	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT L	ise retired)		Wallac		
	Hygie Hygie other ent, II		17. Father's Name (First, Middle, Last)	4	витта	Ing !	Superintendan 18. Mother's Name				n Church
lan	fental fental rked c	To Be	Wesley Albert Swe	at, Sr.			Grace N	4cCa11			
Maryland	and A		19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailir	ng Addres	s (Street and Number or Rur		City or Town,	State, Zip Co	ode)
	and lealth m 27 her tr		Anne A. Sweat - W		107	White	Birch Court				
Baltimore,	ages 1 nt of H : If Its		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Terrioval Iroini State	ace of Dispo emetery, cren		i		20c, Location -	•	
Iţi	artmer artmer ortant injury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Savice Licens</li> </ul>				ematory $\mid 1/11$	/2004 A	Alexand	ria, V	/irginia
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	Physician		Immediate Cause (Final disease or condition	Co	uge	-5+	rive Hear	+ Fa	ilun	e   °	31/eurs
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ion	inding Phi ath. r: Alter thi	atloi	1 ■Naturat 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐ No				
Division	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At hos building, etc. (Specify,	)			28f. Location (Str. City or Town,	State)		
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	To the within To the compl	Me	29b. Signature and title of certifier			29	c. License number	29	d. Date signed	(Month, Day	v, Year)
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1	4 11	a	30. Name and address of person who co	and manner stated.  Carrier Temporal Programme Temp	23a) (Type, 1	Print)	way cre	eubel;	+ mo	20?	70
7	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 4 2004	32. Registrar's Signat	ure	<i>y</i> ,					

DHMH 17 Rev 1/2001

Wesley Albert Sweat Jr.

ORIGINAL

· ·		1 - For 1-22-04 Registra-inend #'s5.8.&  1. Decedent's Name (First, Middle, Last,	State of Maryla 17.PerFam.PGC o		artment rtificate				lental H	Reg. No.	711	04	3. Time	of Death
Physic		Clara Bertice Sa							Month Jan	13 Day	20	Year <b>004</b>	8:33	
/Med Exami		4a. Facility Name (If not institution, give			4b. City, 1	Town, or	Location of	of Death			County		0.00	
		8213 Joselle Cour	ct		Ft V	lash:	ingto				Geo	Co		
Funera Director		Z13-Z0-4733	7. Age (In yi	s. last birthday)  Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of E	Birth <b>NOV</b> Day, Year) - 1920	10,		olace (Stat ntry) rgini	
and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation							1	0d. Inside	City Limi
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5-0056 72 hours after death with the Maryland ratural; or Items 23s or 28s-f show disal Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decede f Yes, speci 1 ☐ Yes 2			gin? (Spe i, Puerto I	ecify Yes or N Rican, etc.)	No-		k, White,	can Indian, etc. a <b>ck</b>	
A I.Z.I.D-UUSO Id within 72 hours at giene. ar than "natural", or the Madical Exam	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced (Give life.	dent's Usual kind of wor DO NOT use	l Occupa k done d e retired)	ition Ju <i>ring most</i>	t of workin	ng	16b. Kii	nd of Bus	siness/In	dustry	
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Maryland Z id 2 should be filed tith and Mental Hygi 27 is marked othar traumatic evant, 1.	To Be (	17. Father's Name (First, Middle, Last) Charles McKinley Charles Edward Am	Armstead <del>mstead</del>						(First, Midd hepher		Sumame	e)		
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of He		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, crer tropoli					14 20				ia, V	
baltimo permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Ligens	Johnson	)	. Name and				PA	6503 Temp]				
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oo / ou, tificate be executed g physician and as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a cons		heas It n		igno		1					
hecolds, F.O. BOX 08 The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pre Other (spe					2	3d. Date Mont		ery Day	Year
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VISION OF VICE Attending Physician: r death. actor: After this certific by the funeral director,	tlon: To	1 Yes 2 No   27. Manner of leath 1 Natural 5 Pending investigation	1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year)	28b. Time of	_	Bc. Injury Work	4 L Nui	2	ne 5 🔀 Res 28d. Describe				/)	
DIVISIO	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)				-	28f. Location City or To	(Street and own, State)		r or Rura	l Route No	ımber,
To the Hospital or At within 24 hours after of To the Funeral Director plate in by the Completely filled in by	Medical C		sician: To the best of my k ner: On the basis of exami and manner stated.											)(s)
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(10)		30. Name and address of person who co			Print)	Ave	, +e	mpl	e hi	16 1	10.	20	745	5
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		•	For State Registrar	State	of Maryland		irtment of H tificate of L			giene 2 ( Reg. No.		03193
			1. Decedent's Name (First, Middle,	Last)					2. Date of Dea Month	Day	Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, g				4b. City, Town, or			4c. County		C 1 -
			9885 Greenb		7. Age (In yrs. k	act hirthday)	If Under 1 Year	reenbelt	9 Date of Birt	<u> </u>		George's
	Funeral		5. Social Security Number 126–20–6059	. Sex 1 □ M 2 □ F	7. Age (iii yis. ii		Months Days	Hours Min.		Year) 2, 1915	Coun	ace (State or Foreign try) Sh., DC
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puelo	y aric		10a. State '10b. County		10c. City	, Town or Lo	cation				1	Od. Inside City Limits
Ma	a-fa	ctor	Maryland Princ	e George	's		Greenbe	1t				1 ZÃYes 2 ☐ No
ŧ	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V		
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5	l', or	by	3 XWidowed 4 Divorced	If Yes, G Year or I	ive		I□Yes 2□XNo	Specify:		Specify	: B:	lack
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מומ	d oth	Be	17. Father's Name (First, Middle, La					18. Mothers Na	me (First, Middle,	te M. H		
2	narke	မှ	Eugene W.  19a. Informant's Name/Relationshi			10h Mailir	Address (Street	and Number or Ri				Code) 20772
2 2	d 2 Si th and 17 is r traur		Rochelle S. Ch		- Niece		10103 Spr					
<b>9</b>	Heal Heal tem 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other place	-a)	Date	20c. Location -	City or To	wn, State
ē į	ages ent of nt: If i		1 ⊠Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe		State		1n Cemete		3/2004	Brent	wood	, MD
аппо	permit. Pages 1 and 2 should be filed within 72 hours after operit with the maryland. Department of Health and Mental Hygiene. Importent: If time 27 is marked other then "naturel", or items 23s or 28s-f ahow any injury or other traumatic event, Ite Medical Examinar must be notified at once.		21. Signature of Funeral Service Li	censee	ہید با	22	. Name and Addres	ss of Facility St	tewart Fu	ıneral H	lome	
ñ	Depa Impo any ir		low.	Stewa	N III		4001 Benr	ing Rd.	N.E. Wa	ash., DC		019
			23a. Parth. Enter the disease, or c shock, or heart failure. List o	omplications that nly one cause on	caused the death each line.	. Do not ent	er the mode of dyin	g, such as cardia	ç or respiratory ar	rest,		Approximate Interval Between Onset and Death
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	ned Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	4	(	•			/			
<u>,</u>	exectin and ial-tra	Exa	resulting in death) Last	Due to	o (or as a consequ	uence of):						
04/8 8/60	cate be executed physician and the burial-transit	dical	1	d								
D D	ntifica ing ph e as th	Med	IF FEMALE:									
Š P	death certific e attending p id for use as	an/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 ☐ Fetal	death 3	Ectopic pregnancy	,		23d. Dat Mo	e of delive nth	nry Day Year
	the dea by the a ached fo	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□Unk	gnant at time of de nown	eath 5L	Other (specify) _					
<b>.</b>	that the de led by the a detached f	P.	Part II. Other significant condition	s contributing to	death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use cont	ribute to th	ne cause of death?
Vital Records,	S	d by	Dulauona	V 9/	Mbol	ism	)		10,	Yes 2□No	3 🗌 Prob	ably 4 \Unknown
် ပ	w require been si should t	lete	Para Mai	ho	out L	ailu	ue_		24a. Was		Nere auto	psy findings available
T	The la ate has page 2	Completed	Said Chia	0 10	mal 1	2.11	10 - de	alwed	autor perfo 1 □ Yes	rmed?	death?	mpletion of cause of 2□ No
<u>ra</u>	an: T tificat tor, p	BeC	25. Was case referred to medica			un		26. Place of De	ath (Check only o			
<b>≥</b>	ysici	To B	examiner?  1  Yes 2  No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing	Home 5 🛣 Resid	dence 6 □Oth	er (Specif	y)
o c	ng Pł fter tr ineral	ä	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	/8.40	e of Injury onth, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injury occur	ed	
<u> </u>	Attending Physician: The laving death. ector: After this certificate has by the funeral director, page 2	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	at ho	AA ba			Yes 2 ☐ No	28f Location /	Street and Numb	er or Rura	J Route Number
Division	or At after of Direct in by	Certification;	4 Homicide determin	200. Fla	ding, etc. (Specif	y)	reet, factory, office		City or To		or or reare	i Tigato Admibat,
	spitel		29a. Certifier 1 Certifying	Physician: To t	ne best of my kno	wledge, deat	h occurred at the tir	ne, date and plac	e, and due to the	cause(s) and ma	nner as s	tated.
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	edical	(Check only 2 Medical E	xaminer: On the	basis of examina inner stated.	tion and/or in	vestigation, in my d	pinion, death occ	curred at the time,	date and place,	and due to	o tne cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier	-	\		29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
)	0		Cus	10	YAC	11	ce 14	3/2		01/12	104	<i>H</i>
	CK (5	1	30. Name and address of perso	1	ure of death (It		St., N.W.	Suita	S 406 17	ach DO	20	010
	7		Carol Jago 31. Date filed (Month, Day, Year)	leo, M.D	Registrar's Signa		DL., N.W.	Surre	400, W	asii., DC	, 20	010
	St Regist	ate trar	JAN 1 5 20	04	Registrar s digital		de s					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2, 2004 Jan. 6:05A Stafford Bertha B. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Pineview Nursing Home P.G. Clinton 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☑ F 579-32-6158 22, 92 1911 March Md. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State r than "natural", or itams 23a or 28a-1 show the Medical Examinar must be notified at 11X Yes 2 □ No **Funeral Director** Md -P.G. Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9106 Pineview Lane 20735 United States 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Be Completed by 3 □XWidowed 4 □ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie 1ant: If itam 27 Is markad othar t jury or other traumatic evant, Ib 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mammie Butler Rufus Stafford ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3900 Regency Pkwy #206
Suitland, No. 20746 19a. Informant's Name/Relationship (Type, Print) Roberta Jackson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages Department of i Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/04 Lincoln Cemetery \* 4 □ Depation 5 □ Other (Specify) Suitland, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md.20746 cewaro Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy 2X No 1 ☐ Yes 2 XNo 1☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4XX Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 🖾 latural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after To the Hospital within 24 hours a To tha Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30 Name 31. Date filed (Month, Day, Year) State **JAN 15** 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland /	Depa <i>Cer</i>	artment of He tificate of D	ealth and Death	Mental Hyg	giene 2	004	03195
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Bay 85	Y.ear	3. Time of Death
	/Medic		Wilfred George Stephenson				-		₹°	9:00p.
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I		ath		nty of Death	
			Forest Glenn NUrsing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last t	birthday)	Silver If Under 1 Year	Spring If Under 24 Hr	s. 8. Date of Birt	h	t gome 1	Dlace (State or Foreign
	Funeral Director		577-78-4841 1⊠M 2□F 82	Yrs.	Months Days	Hours Mir		y, Year) 21	_ Cou	ica W.I.
	ъ		Usual Residence of Decedent							
	ahow	Ļ	10a. State 10b. County 10c. City, To	wn or Lo	cation				1	10d. Inside City Limits 1 ✓ Yes 2 □ No
	8a-f	Directo		ningt						
	with t	吉	10e. Street and Number		10f. Zip Code 20012			10g. Citizen US		ntry?
	ns 23	Funeral	1242 Van Buren Street N.W.  11. Marital Status 12. Was Decedent Ever in U.S.	13. \	Vas Decedent of His	panic Origin?	Specify Yes or No-		A lace - Americ	can Indian.
0	fler d	표	Armed Forces? 1 □ Never Married 25 Married 1 □ Yes 2 1 No	11	f Yes, specify Cuban	, Mexican, Pue	irto Rican, etc.)	E	lack, White,	etc.
ğ	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	∐Yes 2∏XNo	Specify:		Spe	city: Bla	ck
S C	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	Sa. Deced (Give	lent's Usual Occupat kind of work done du OO NOT use retired)	tion uring most of w	orking	16b. Kind o	Business/In	dustry
121	Mithin Ine.	g I	Elementary/Secondary (0-12) College (1-4or 5+) Se		oo NOT use retired) se Station		_	EXXO	J	
N D	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-f show ant, the Madical Exaculturer cost be notified at	ပိ	17. Father's Name (First, Middle, Last)				ame (First, Middle,	Maiden Sun	ame)	
Č.	0 7 5	To Be	Wilfred Stephenson				re McKins		,	
3	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene Is marked other than "natural", or items 23a or 28a-1 show tarmatic event, If a Madical Exa. Ither cast to nutified at	-		9b. Mailin	g Address (Street ar				vn, State, Zip	Code)
Ž	alth a alth a 127 is		Minnie G. Cox Stephenson Wife 12	242 \	Jan Buren	St. N.	W. Washin	gton,	D.C.	20012
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic e once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Dispos tery, cren	sition (Name of natory or other place,	)	Date	20c. Locatio	n - City or To	own, State
Ĕ	Pag ment ant: I	1		k Cre				lashing		
3at	permit. Depart Import any inj		21. Signature of Funeral Service Licensee		. Name and Address					
	0 0 ≥ e 0		PMarshall		217 9th. 9				).C. 2	
			23a. Pafit Entel the disease, or complications that caused the death. Distrect, or heart failure. List only one cause on each line.	o not ente			ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	レー	2 Cana	4			i	hlenows
	Examiner		Due to (or as a consequence	e of):	<i>(</i>					
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	e of):						
	outed id ansit	Examiner	f any, leading to immediate cause. Enter Underlying Causa Ca							
o,	a exection and and and and and and and and and an	Ex	resulting in death) Last Due to (or as a consequence	e of):						
8760	cate be executed physician and the burial-transit	dlcal	d							
9		/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy							
Вох	eath certif attending for use a	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)				Date of delive Month	ory Day Year
o.	that the di ed by the detached	ysk	1  Yes 2 No 9 Unknown 9 Unknown		( Other ( Specify)					
J.	The law requires that the tee has been signed by though 2 should be detached.	by Pi	Part II. Other significant conditions contributing to death but not resulting	g in the ur	nderlying cause giver	n in Part I.	23e. Did to	bacco use c	ontribute to th	ne cause of death?
ğ	w require: been sig should b						1 🗆 Y	es 2□No	3 Prob	ably 4 Duknown
ပ္ပ	law requ as been 2 shouk	Completed					24a. Was a	an 24	o. Were auto	psy findings available mpletion of cause of
ř		LO C					perfor	med? 2/□No	death? 1 ☐ Yes	
/ita	cian: ertific sctor,	Be (	25. Was case referred to medical examiner?				eath (Check only or	ne)		
<u></u>	Physi this c	၉	The second secon	Outpatient		4 Limitsing	Home 5 Resid			/)
u O	ding I h. After funer	tlon	1 ☐ Natural 5 ☐ Pending (Month, Day Year)	Injury	Work?	es 2 No	28d. Describe h	ow injury occ	urrea	
Division of Vital Records,	tten deat ctor:	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home,	farm, stre					n <i>ber</i> o <i>r Rur</i> a	l Route Number,
á		Certification:	4 Homicide determined building, etc. (Specify)				City or Tow	n, State)		
	To the Hospital or within 24 hours after To the Funeral Director completely filled in		29a. Certifier (Check only (Ch	ige, death	occurred at the time	e, date and place	ce, and due to the d	ause(s) and	manner as si	ated.
	To the H within 24 To the F complete	Medical	one) and manner stated.					<u> </u>		
	To the within To the comple	2	29b. Signature and title of certifier		29c. License			29d. Date sig		uay, rear)
0			I don't don't	. =	KSOY	34	X	Jas	aug	913704
2	(2)		30. Name and address of person who completed cause of death (Item 23a 980   Cersia Ave 3-41 8, ) v		Print) PRING M	0209	102			
	Sta	te	31 Date filed (Month Day Year) 2 Registrar's Signature			1)				
	Registr		JAN 1 5 2004 Seem &	Span	e e					

	give street and number)  HOSPITAL CENTER	CHEVER			NCE GEORGES
5. Social Security Number 578–25–7346	6. Sex 1 □ M 2  F 7. Age (In yrs. las	Yrs. Months Days	Hours Min. (Month	of Birth h, Day, Year) /90	Birthplace (State or Foreign Country)  Wash.,D.C.
Usual Residence of Decedent  10a. State  10b. County		Town or Location			10d. Inside City Limits  Yes 2 □ No
Maryland  10e. Street and Number	пуас	10f. Zip Code		10g. Citizen of W	
5369 Quincy Str		20784			S.A.
10a. State   10b. County	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of h If Yes, specify Cub 1 ☐ Yes 2 X No	Hispanic Origin? (Specify Yes of an, Mexican, Puerto Rican, etc Specify:	Specify:	o - American Indian, k, White, etc. Black
15. Decedent (Specify only highest Elementary/Secondary (0-12) 8th	t's Education st grade completed)  College (1-4or 5+)		pation during most of working d)	Public S	School .
8th  17. Father's Name (First, Middle,	( act)	Student	18. Mother's Name (First, M		George's Co.
Attwaye J. Jack				J. Sutton	
19a. Informant's Name/Relations		19b. Mailing Address (Street	and Number or Rural Route N	lumber, City or Town,	State, Zip Code)
Lisa J. Sutton	/mother		Street #1 Hyatt	tsville, Mo	1. 20784 City or Town, State
20a. Method of Disposition  1 Burial 2 Cremation	- Cei	ce of Disposition (Name of metery, crematory or other pla	ice)	Adelphi,	
4 Donation 5 Other (S  21. Signature of Funeral Service	pecify) GeO	rge Wash.Cemet		_	, 1.u.•
Many E. He	//		Funeral Home,		001
23a Part 1 Enter the disease, or	complications that caused the death.	Do not enter the mode of dy	ing, such as cardiac or respirat	ory arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)		tion and There	mal Injurie <del>s</del>		Onset and Death
Sequentially list conditions, in any, leading or immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a sorresque	ariou of):			
a any, leading to immediate cause. Enter Underlying cause (Disease or injury that imitated events resulting in death) Last	c. Due to (or as a conseque	ence of):			
<u>-</u>	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of pregnan 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 Ectopic pregnand	су	23d. Dat	e of delivery nth Day Year
A Partin other signment contain	ons contributing to death but not resu	lting in the underlying cause g	iven in Part I. 23e.	Did tobacco use control 1 ☐ Yes 2 🕱 No	nbute to the cause of death?
Completed				autonsy	Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	Hospital:	ER/Outpatient 3 DOA	26. Place of Death Check ther: 4 Nursing Home 5		er (Specify)
F 2525	ng (Month, Day Year)	28b. Time of 28c. Injury W	ork? □Yes ¾XNo Subi	ect in hou	
27. Manner of Death  1	not be 1/9/04 2	me, farm, street, factory, office	28f. Loca City	ition (Street and Numb or Town, State)462 Pleasant.	I Addison Rd.

State Registrar

31. Date filed (Month, Day, Year)

JAN 2 2 2004

32. Registrar's Signature

		1 - For State Unpend Item #23a Registrar		10, Certific	ate of De	eaur	Reg	g. No. 💪 U U 🖟	+ 0319
Physici	an	Decedent's Name (First, Middle, Last)					<ol><li>Date of Death Month</li></ol>	Day Yeer	3. Time of Death
/Media		Thomas Charles	Stewart	1			January		
Examir	ner	4a. Fecility Name (If not institution, give				ocation of Death		4c. County of Dee	
		Suburban Hospita  5. Social Security Number 6. Se			Bethesda nder 1 Year   I	a f Under 24 Hrs.	8. Date of Birth	Montgam	
Funeral Director			§м 2□F 65	Yrs. Mont	ths Days	Hours Min.	(Month, Day, ) Dec. 18, 19		thplece (State or Fore ountry)
		Usual Residence of Decedent					500.20,2.	, was	illig con , D.
how	_	10a. State 10b. County Maryland Prince Ge		Town or Location	110				10d. Inside City Lim
88-11	cto		11.						1x Yes 2□
s I and 2 should be lied within 72 hours after beant with the maryland. The alth and Mental Hygiene. It health and Mental Hygiene. It has a show from a start of the short that the marked other than "natural", or from a start be not lifted at other traumatic event, the Medical Examiner is ust be not lifted at	Completed by Funeral Director	10e. Street and Number	1.1	10f.	Zip Code		100	g. Citizen of What C	,
s 23s	ral	11011 Spyglass Hil		i. 13. Was De	20721	ania Origina /Sau	nafu Van as Na	United S	
item it	ů	11. Marital Status  1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☒ No	If Yes,	specify Cuban,	anic Origin? (Spe Mexican, Puerto	Rican, etc.)	Black, Whi	
9.0	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Ye	s 2X No	Specify:		Specify: B	Lack
atura	ted	15. Decedent's Edu	cation	16a. Decedent's l	Jsual Occupation	on	. 16	5b. Kind of Business	Andustry
than "n	ple	(Specify only highest grad	College (1-4or 5+)	life. DO NO	T use retired)	ing most of work	ng		
Hygien Sther th	Con	12		Servi	ce Spec			Private	
d oth	Be	17. Father's Name (First, Middle, Last)			18		(First, Middle, Ma	aiden Sumame)	
should be the Mental I marked o umatic eve	ဥ	Charles Rustin				Mary Q			
and raum		19a. Informant's Name/Relationship (T) Barbara Stewart /						City or Town, State, Lle, Md. 20	
Health Iem 27 other tr		20a. Method of Disposition	•						
nent of H int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	metery, crematory	Cremato	ry,	20 0004	oc. Eccation - City of	TOWN, State
		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Lice is	meti	copolitan	a and Address of	Jan.	28,2004 A	oc. Location - City or	ı, Va.
Departin Imports any inju		21. Signature of Furieral Service Licens		- ATE	xander 8 Marih	S. Pape	Funeral	Homes ville, Md.	20747
		23a. Part1. Enter the disease, or comp	lication that caused the death						Approximate
nysician /Medical ixaminer	er.	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	Due to (or as a consequent).  Due to (or as a consequent).	ence of):	ascular d	lisease			Onset and Death
nsit	- Lu	Sequentially list conditions, if any, leading to immediate cause. Enter U Jerryhng Cause (Disease or injury	240 (0 (0) 25 4 00110045	31100 01).					
hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequent	ence of):					
Sicient b buri	cal		d						
g phys	edic		u						
w requires that the death certaincate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 ☐ Ectopi	ic pregnancy (specify)	- II		23d. Date of de Month	livery Day Year
ned b	by Pt	Part II. Other significant conditions co	ntributing to death but not resul	ting in the underlyir	ng cause given i	in Part I.	23e. Did toba	cco use contribute to	o the cause of death
as been sign 2 should be	Q D						1 ☐ Yes	2 □ No 3 □ P	robably 4 Unkno
s bee	Completed						24a. Was an	24b. Were a	utopsy findings availa
ate ha	E						autopsy	ed? prior to death?	
this certificate has	0	25. Was case referred to medical			2	6. Place of Death	(Clieck only one)		5 140
is cer direc	To B	examiner? 1 A Yes 2 No	Hospital: 1   Inpatient 2	R/Outpatient 3	DOA Other:			ce 6 ☐ Other (Spe	icify)
		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe how		
r death. octor: After	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(, -=,,	M		s 2 🗆 No			
in the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, fac	ctory, office		28f, Location (Stre City or Town,	et and Number or R State)	ural Route Number,
24 hours a Funeral letely filled	edical (	29a. Certifier 1 Certifying Phy	sician: To the best of my know iner: On the basis of examinati and manner stated.	rledge, death occur on and/or investiga	red at the time, tion, in my opini	date and place, a ion, death occurr	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	s stated. e to the cause(s)
within 2 To the	Me	29b. Signature and title of certifier	^		29c. License n	umber	290	I. Date signed (Mont	h. Day, Year)
- > - 0	i	Y X Joshow	N)		0.	C.M.E.		January 20	, 2004
		30. Name an address of person who o	ompleted cause of death (Item	23a) (Type, Print)					

			1 - For State Registrar	State of Maryla			of Health and of Death		jiene 19g. No. 2	004	03198
ij	Physici /Medic		1. Decedent's Name (First, Middle, La	Thomas		4h Cin To	un or Location of Do	2. Date of Dea Month	Day	Yeer 2004 ty of Death	3. Time of Death
	Examin Funeral Director	ier	4a. Fecility Name (If not institution, giv  UNIVERSITY of Maryla  5. Social Security Number  220-62-8711	nd Medical Syst	CM s. last birthday) Yrs.	Bal-	wn, or Location of De TIMOTO Tear If Under 24 H Days Hours M	Irs. 8. Date of Birth	r, Year)		lece (State or Foreign try) Land
	0	rector	Usuel Residence of Decedent  10a. State 10b. County  Maryland St. Mary  10e. Street and Number		ity, Town or Lo	ocation 10f. Zip Co	ode		10g. Citizen of	11	0d. Inside City Limits 1 ☐ Yes 2 No
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If term 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examinal must be notified at once.	by Funeral Director	38705 Dickerson 1  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Road  12. Was Decedent Ever in Armed Forces?  1 IXYes 2 □ No If Yes, Give Year or Dates:		Was Decedent fryes, specify	_	(Specify Yes or No- erto Rican, etc.)	Bia	ace - Americ ack, White, o ify: Bla	etc.
717	filed within 72 hou Hygiene. Sther than "nature ent, the Madical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Co kind of work of DO NOT use pply Co	done during most of vetired)		US Gov	ernmer	•
ylan	should be fill and Mental His marked oth umatic even	To Be	17. Father's Name (First, Middle, Last  Truman Hillia:  19a. tnformant's Name/Relationship (	ry Thomas		-	France Street and Number or	Name (First, Middle, S Teresa Rural Route Number	Armstro	ong n, State, Zip	
e,	Pages 1 and 2 nent of Health a nut: If itam 27 is rry or other tra		Shirley Ann Thoma  20a. Method of Disposition  **ABurial 2 Cremation 3 C  * 4 Donation 5 Other (Speci	Removat from State	Place of Dispo	osition (Name matory or othe	of or place) Janu	Date ary 13, 004	Marylan 20c. Location Bushwood	- City or To	wn, Stete
	permit. P Departm Importar eny inju		21. Signature of Funeral Service Lice  23a. Part 1. Enter the disease, or com-	(men	Ma P	2. Name and A attingle .O. Box	Address of Facility y-Gardiner F 270, Leonard	uneral Home town, Maryla	P.A. and 2065		
*i	death certificate be executed  Madicial and certificate and certificate as the burial-transit  d for use as the burial-transit	Ilcal Examiner	shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Alcoholic Due to (or as a consect Due to (or a) Due t	infla equence of): Cirrhosi equence of):	mmeta 's bicterca			dume		Approximate Interval Between Onset and Death
O. Box 6	death certific e attending p id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic preg □ Other (spec				ate of delive	ory Day Year
ecords, P.	law requires that the as been signed by th 2 should be detache	by	Part It. Other significant conditions	contributing to death but not re	esulting in the u	underlying cau	se given in Part I.	_ 1 □ Y	es 2□No	3 Prob	ably 4 NUnknown
Ÿ	The ate h page	Be Completed	25. Was case referred to medical examiner?				26. Place of I	24a. Was a autop. perfor 1 Yes	sy med? 21 No	prior to cor death? 1 \sum Yes	psy findings available inpletion of cause of
Division of V	or Attending Phys Itler death. Director: After this in by the funeral di	Certification: To F	1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to determined	28a. Date of Injury (Month, Day Year)	ER/Outpatie  28b. Time of third thir	of 280	. Injury at Work?	g Home 5  Resid	ow injury occu	urred	r) I Route Number,
	To the Hospitaf within 24 hours a To the Funeral E completely filled	Medical C	29a. Certifier (Check only one)  29b. Signature and title of certified	miner: On the best of my k miner: On the basis of examinand manner stated.	nowledge, dea nation and/or in	estigation, in	i my opinion, death o	courred at the time, o	date and place	e, and due to	the cause(s)
	St	ate	30. Name and address of person who Matthew Smith 10. 31. Date filed (Month, Day, Year)	completed cause of death (It South Greene St 32. Registrar's Sig	em 23a) (Type	, Print) Balti	P16493	royland	Januar	7 0	, 5007

William Tilghman Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please  1 - State Registrar	State of Ma		Depai		lealth and M	Mental Hy	giene	2001	03199
Physicia	_	Hegistrar      Decedent's Name (First, Middle, La  WILLIAM	SI) TILGUN	1AN -	JR	1		2. Date of De. Month Januar	Day		3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, given Memorial Hospita	_			4b. City, Town, or Easton	Location of Death		4c.	County of Deat	
Funeral Director		5. Social Security Number 6. 3 217 30 7753		(In yrs. last bi	rthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird Month, Da	v Yearl	Co	hplace (State or Foreign unity) IC-Daniel, Md,
Maryland f show	tor	Usuel Residence of Decedent  10a. State 10b. County  MD TAU	b-T	10c. City, Tow	on or Loca						10d. Inside City Limits 12 Yes 2 □ No
h with the	al Direc	10e. Street and Number	TREET			10f. Zip Code	01			zen of What Co	untry?
within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show the Marical Exertiner must be notified at	by Funeral Director	11. Marital Status  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Mes 2 Mes If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba	ispanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	-	14. Race - Ame Black, White Specify: BL	
within 72 hou sne. than "neture e Madical E	Completed	15. Decedent's Elementary/Secondary (0-12)			(Give k	ent's Usual Occupa ind of work done of O NOT use retired	during most of wor 1)	king		nd of Business	
uld be filed Mental Hygie Irked other ritic event, II	To Be Co	17. Father's Name (First, Middle, Last	Tilahma	ũη			18. Mother's Nam	6		Sumame)	7
and 2 sho eaith and I n 27 is ma ter treume		19a Informant's Name/Relations & ELISC BLOC	Type, Prin	3	081	E-24th	and Number or Ru	mingt	00	De. 1.	9802
permit. Pages 1 and 2 should be tiled within 72 hours after death with the Manylan Inpertment of Health and Mental Hygiene. Impertents if item 27 is marked other than "neturel", or Items 23e or 28e-1 show any injury or other treumetic event, the Madical Examinat must be notified at once.		20a. Method of Disposition  Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci  21. Signature of Funeral Service Lice	fy)	20b. Place of cemeter Man	y L	ition (Name of atory or other place AND VE Name and Address Bennie St	FORMS / Sept Specific from the form of Facility mith Funder Street,	23-04 eral Hom	<i>Н</i> ц,	eLock	, Maryland
Physician and // Physic	Ical Examiner	23a. Part1 Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	the death. Do le.	cato			you'd	rest,		Approximate Interval Between Onset and Death
es that the death certificate igned by the attending phys be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal death		Ectopic pregnancy Other (s <i>pecify)</i>			2	23d. Date of deli Month	very Day Year
quires that t n signed by uld be detac	þ	Part II. Other significant conditions  prostate Can		ut not resulting	in the und	derlying cause give	en in Part I.		obacco u /es 2[		the cause of death?
: The law require cate has been siç , page 2 should b	Completed								rmed? 2 No	24b. Were au prior to death? 1 □ Yes	topsy findings available completion of cause of
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigatic 2 Accident 3 Suicide 6 Could not	20	y Year) 28b.	utpatient Time of Injury		4   Nursing H	ome 5 ☐ Resid	dence 6	y occurred	
To the Hospitel or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fi		4 Homicide determined	28e. Place of Injubulding, etc	c. (Specify)			oo dato and place	City or Tov	vn, State,	)	ral Route Number,
the Hos thin 24 ho the Fun mpletely	Medical		miner: On the basis of	examination at			pinion, death occu	rred at the time,	date and		to the cause(s)
To To		rall my	Mandre	2 N	D	D3(	0644		1/1	6/04	
		30. Name and address of person who		an A	50		iulu ave	EAS-	1001	MD	21601
Sta Registr		31. Date filed (Month, Date)	1 200 62. Red	ar's Signature	9. 19	ped					

State of Maryland / Department of Health and Mental Hygiene? [] [] [... Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 3, 2004 3:45PM Helen Novella Wheeler Thornton January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Cambridge Chesepeake Woods Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Director 163-18-7257 March15,1912 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exertinal mast be notified at 1 XYes 2 No Directo Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 525 Glenburn Ave. 21613 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after ☐Yes 2XNo 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Specify: ģ Specify: 3 Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ue filed with. La Mental Hygiene. S marked other the Elementary/Secondary (0-12) College (1-4or 5+) 5 Some one else's home Home maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental F Wheeler Mary Anthony permit. Pages 1 and 2 shr Department of Health and Important: If item 27 is m. sny injury or other traum: once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 4938 Drawbridge Road, Cambridge, Maryland 21613 Harris Nellie Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church Hill Cemetery 01/10/2004 ChurchHill, Maryland 21. Signature of Fur erat Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 524 Race Street, Cambridge, Maryland 21613 rince JUM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence Examiner certificate be executed physician and s the burial-transit Box 68760 Physician/Medical as the attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 2 10

9 Unknown detached for Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 2 No. 3 Probably 4 Unknown icate has been sig , page 2 should b 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 1 ☐ Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 1 Yes 2 100 P 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred al or Attending P after death. 1 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide e Hospital 24 hours a within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Midical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26386 Lelders ess of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Michael Fadden, M.D.

31. Date filed (Month, Day, Year)

W Û

32. Registrar's Signature

302 Collins Ave., Hurlock, Maryland 21643

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 4004 Januar David Lawrence Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Ridgely 23280 Ninetown Road If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F Yrs Dec. 8,1940 Director Maryland <u> 221-44-4567</u> 63 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Ridgely Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō U.S.A. or Items 23a 21660 23280 Ninetown Rd by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A Disabled 8 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oths any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Della Mae Thomas Roland Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21639 121 N Main St Greensboro, MD <u>niece</u> <u>Azalie Ina Wise</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【\*\*\* Cremation 3 ☐ Removal from State \*\* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 01/22/2004 Chester, Maryland 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home PA 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PO Box 160 Greensboro, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): Examiner PERTENSIVE CARDIOVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. be detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 Mo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 ☐ Yes 2 ☐ No N/A 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∰Yes 2 No Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DEPUT 29c. License number January 21 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EJENSEN MD POB# =690, DEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

		•	1 - For Amend Item Registrar	#5 State of	Marylan 1 6829	3/22782 Cer	rtment of tas tificate o	Health and f Death	Re	g. No.	03202
	Dhyaiai		1. Decedent's Name (First, Middle,	Last)					2. Date of Death _ Month	Day Year	3. Time of Death
	Physicia /Medic		Rodney Alan	Taylor					Januar		
	Examin	er	4a. Facility Name (If not institution,					n, or Location of Dea	th	4c. County of Death	
			3780 Helwig I		7. Age (In yrs.	last hirthday)	IN all	jemoy ar   If Under 24 Hrs	8. Date of Birth	9 Birth	plece (State or Foreign
6.	Funeral Director		282 in 78 unity 5 62 or 282 - 78 - 1762	1. 2 F	33	Yrs.	Months Da		Sept.	18 1970 co.	OH
4			Usual Residence of Decedent								
	how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	MD Char	Les		Nanje	7				1 ☐ Yes 2 ☒ No
	ath with the Marylar 23s or 28s-f show ust be notified at	Dire	10e. Street and Number	n 1			10f. Zip Cod		10	g. Citizen of What Cou	intry?
	death with the Maryland rms 23a or 28a-f show rmsst.be nutfilled at	Funeral Director	3780 Helwig Fa		edent Ever in U	C 12.1		0662 of Hispanic Origin? (	Specify Yes or No.	USA 14. Race - Amer	ican Indian
	Item Item	'n.	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie	Armed Fo	rces?		f Yes, specify C	uban, Mexican, Pue	rto Rican, etc.)	Black, White	, etc.
936	urs af al', or Exam	by	3 ☐ Widowed 4 ☐ Divorced	17.17		-2004	1 ☐ Yes 2 ☐X	No Specify:		Specify: Wh	ite
Ď	filed within 72 hours after Hygiene. other then "netural", or Ite ent, the Madical Exemine	Completed	15. Decedent's (Specify only highest	Education		16a. Deced	ient's Usual Oc	cupation ne during most of wo	orking 1	6b. Kind of Business/I	ndustry
21	ithin 7 19.	nple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. I	DO NOT use re	tired)	9	C	
2	ygien ygien yar th		12			Sta	ff Ser		me (First, Middle, M		r Force
ğ	be fill bd ott	Be	17. Father's Name (First, Middle, L. Donald Taylo:	,						ay Taylor	
<u>~</u>	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "natural", or Items aumatic event, the Macical Examinerm	오	19a. Informant's Name/Relationshi			19h Mailir	na Address (Str			City or Town, State, Zi	
ltimore, Maryland 21215-0036	is 1 and 2 should of Health and Men item 27 is marke other traumatic		Carolyn M. Tay		fe					emoy,MD 2	
ē,	tem 27	. 13	20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other	nlace)	Date 2	Oc. Location - City or T	own, State
9	Pages nent of int: If it iny or o		Donation 5 Other (Sp.						em. 1/26,	/04 Stove	rtown,OH
a	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service L	censee, /		, _ Å <sup>2</sup>	REHART	dreg CHOLS	FUNERAL	HOME, P.A	
m	P P P P P		Naud C.	lest	M009				Plata,M		
H			23a. Pert1. Enter the disease, or of shock, or heart failure. List of	omplications that c nly one cause on e	aused the deat ach tine.						Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	ACU	TE	My.	ELOC	SENOU	isleur	euria	Oliset and Death
30	/Medical Examiner		resulting in death)	Due to	(or as a conseq						
V.		L.	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a conseq	mence of).					
	nsit	nlne	Cause (Disease or injury	540.10	(0. 45 4 50.1504	400100 017.					
<u>,</u>	s be executed sician and s burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):					
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68	ntifica ng ph as th	a)	IE ECHALE.	-							
Вох	eath certific attending p	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of pregna pirth 2 🗆 Feta	al death 3	Ectopic pregna			23d. Date of deli-	ery Day Year
о. П	ne dea the at hed fo	Physiclan/M	1 Yes 2 No	4□Pregn 9□Unkno	nant at time of o own	death 5	Other (specify	·)		World	50,
<u>Ч</u>	that the de ed by the detached	Phy	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the u	nderiving cause	given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds,	signed be de	d by		3		•	, ,	•	1 ☐ Ye	s 2∱SNo 3∏Pro	babiy 4 Unknown
200	w require been si should b	lete							24a. Was an	24b. Were aut	opsy findings available
Re	he lav e has	Completed							autopsy perform	prior to c ed? death?	ompletion of cause of
tal	an: T	a a	25. Was case referred to medical					26. Place of De	1 ☐ Yes 2' eath (Check only one		20110
<u> </u>	ysici is cer direc	To B	examiner? 1 🗆 Yes 2 🗖 🌓	Hospital: 1 🔲	Inpatient 2	ER/Outpatier	t 3 DOA	Other: 4 Nursing	Home X Resider	nce 6 Other (Spec	ify)
0	ng Ph ter th	L:uc	27. Manner of Deat  1. Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o		njury at Work?	28d. Describe how	w intury occurred	
Sio	Attending Physician: Ir death. ector: After this certific. by the funeral director. I	catic	2 Accident investiga	ation			М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	l or Att after d Direct	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	280. Place	of Injury - At hing, etc. (Special	iome, farm, str fy)	eet, factory, off	ice	28f. Location (Str. City or Town,	eet and Number or Rui State)	al Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier JE Certifying	Physician: To the	hest of my kny	Owledge deat	n occurred at th	e time, date and place	and due to the ca	use(s) and manner as	stated.
	the Hospital thin 24 hours of the Funeral I mpletely filled	Medical	(Check only 2 Medical E	xaminer: On the b	asis of examina ner stated.	ation and/or in	vestigation, in r	ny opinion, death occ	curred at the time, da	te and place, and due	to the cause(s)
	within 2. To the I complete	Me	29b. Signature and titte of certifier		1-10		29c. Lic	ense number	29	d. Date signed (Month	Day, Year)
)			Konge	MI	Calle	~	$\mathcal{D}$ :	1835	7	1-71-	04
1	0 .464		30. Name and address of person w	ho completed caus	se of death (Iter	т 23а) (Туре,	Print)	1 1	0-0	10/1	0 /
-	DKT		Y ( )	, 1	272	1	ا می	Cara	1 0	7060	1 0
	Sta Regist		31. Date filed (Month, Day, Year)	3 2004	Registrar's Sign	divise .	goods				

AMEND/10E 1/23/04 AAOO HEALTH DEPT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 18 2004 Veraline R. Truesdale January 1:50 am /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number) 4c. County of Death Examiner Prince George's Hyattsville Heartland Healthcare Months Days Hours Min. Jan. 25 1941 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 万 F Yrs. Jan. 62 Director 216-36-1441 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural" --- any injury or other treumatic average. 10c. City, Town or Location 10d. Inside City Limits 10b. County Ť□¥es 2□No Directo Maryland Prince George's Riverdale 10g. Citizen of What Country? 10e. Street and Number CrestWood Place Funeral 5710 Gr4e 20737 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 23∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas ŽÍNo Specify: Specify: Black ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) D.C. Board of Elementary/Secondary (0-12) College (1-4or 5+) Education 12th Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Nicholson Herbert Jackson ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 5710 Crest Wood Place Riverdale, Mdd 20737 Harry Truesdale (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/23/04 Crownsville, Md. Cemetery 22. Name and Address of Facility
Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 WEst St. Annapolis, Md. 21401 Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) voletras wear Disease Examiner Examiner attending physician and I for use es the bunal-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown End Stare Multiple Scherosis signed Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No this After this funeral 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? 1 2 Natural 5 Pending s after death.
I Director: Aid in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funerel Completely filled 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Yeer) 29b. Signature and litle of certifier JANUARY 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DE VOIE MD 4203 QUEENSSURY Red HYGETTVILLE MA 207 87 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 3 2004 Registrar

DHMH 16 Rev 6/95

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Immediate Cause (Final resulting in death)   Sequentially lat conditions   Sequentially lateral la				23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that only one cause	caused the	e death. Do not ent	er the mode of dyin	g, such as cardiad	or respiratory ar	rest,		Interval Between
Medical Examiner   Featuring in death   Featuring		Physician	87 X	disease or condition		1210	mon i	2					. 1
A style bound of the control of th				resulting in death)	Du to		consequence of):		,	9			2
A style bound of the control of th	Н	Examiner		Sequentially list conditions.	b	NON	110 06.	stlut	ic po	Iman)	14 des	cox	29/5
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25. Was case referred to medical examiner?  1		the death certi the attending ched for use a	ysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live 4 ☐ Preg	birth 2 gnant at tir	Fetal death 3						•
25. Was case referred to medical examiner?  1		quires that n signed by	þ	Part II. Other significant conditi	ons contributing to	death but	not resulting in the u	nderlying cause give	en in Part I.				
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1441/1 07	Θ	s after s after al Dire	Certif	4 Homicide	buil	ding, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tox	vn, State)		
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1441/1 07		To th withir To th comp	Me	29b. Signature and title of certific	er / /	10		29c. License	number		29d. Date signed	(Month, (	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Robert Duriting 973.7 Herific Drive Berlin, my 2/8/1  State Registrar  1AN 1.3 2004  32. Registrar's Signature Apouls				• /	MI	_		444	1283		1/12	104	1
State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  Apacks  34. Date filed (Month, Day, Year)  35. Registrar's Signature	DO	À					ith (Item 23a) (Type, 7733 7	Print) CZ/Mw	24 D.	ive	Be-11	1,1	no 2/8/1
						Rogistrar'	s Signature	Sparks					

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DORIS FOYIGH 221

		_	For State Registrar	01010 01	· · · · · · · · · · · · · · · · · · ·		rtificate of	Health and M Death		Reg. No.	2004	03	205
Phy	/sicia	n	1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea	ath Day	Yeer	3. Time o	
	ledica	al -	JACK B. TAYLOR						January	16	2004	4:45	РМ
Exa	amine	er	4a. Facility Name (If not institution, gi	ve street and num	iber)			or Location of Death			County of Death		
Fune	e e			Sex	7. Age (In yrs. la	ast birthday)	SALISBUR'	If Under 24 Hrs.	8. Date of Birt		9. Birtho	lece (State o	or Foreign
Direc			214-16-4842	1₩ 2□F	81	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, De 03-26-	1922	POCOM	ÖKE, 1	MD.
pug *			Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	ecation				1	0d. Inside C	ity Limite
death with the Maryland	a Dellico	ō	MD WICON	MICO		ISBURY							X□ No
ith the M	TO I	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cour	itry?	
eath wi	diam.	iai [	27940 RIVERSIDE I	DRIVE			21801				USA		
	Die Co	nue	<ol> <li>Marital Status</li> <li>Never Married 2X Married</li> </ol>	Armed For		5. 13.	Was Decedent of F f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	<ol> <li>Race - Americ Black, White,</li> </ol>		
215-0036 thin 72 hours after e.		2	3 ☐ Widowed 4 ☐ Divorced	1 X Yes If Yes, Give Year or Da	9		1 ☐ Yes 2 ሺ No	Specify:		5	Specify: W	HITE	
5-003 72 hours a	Isal	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Dece	dent's Usual Occup	pation during most of work	ina	16b. Kin	d of Business/Inc	dustry	
1215- within 72 ene. than "nai	a We	ğ W	Elementary/Secondary (0-12)	College (1-	4or 5+)			during most of work d)	9	DIID	(D.T.); G. G.	DDT **	
nd 2	o 'i	3	12 17. Father's Name (First, Middle, Las	t)		M	IANAGER	18. Mother's Name	a (First Middle		MBING SU	PPLY	
yland ould be 1 Mental I		To Be	BERTRAN J. TAYLO					MARIE MA		Walger C	amamey		
Maryland 21 d 2 should be filed wi tith and Mental Hygien 27 is marked other th	traumatic		19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Number or Run		r, City or	Town, State, Zip	Code)	
	er tra		BETTY M. TAYLOR -	- SPOUSE		27940	RIVERSI	DE DRIVE,	SALISBU	RY, M	1ARYLAND	2180	1
Baltimore, Sermit. Pages 1 ar Department of Hea mportant: If item.	or other		20a. Method of Disposition  1∑ Burial 2 □ Cremation 3 [	☐Bernoval from S	20b. Pl	ace of Dispo	sition (Name of natory or other plac	ce)	Date	20c. Loc	ation - City or To	wn, State	
Baltimor permit. Pages Department of H Important: If ite	dany		*4 ☐ Donation 5 ☐ Other (Special	ity)			T CEMETE				POINT,		AND
Bal Sermit	any in		21. Signature of Funeral Service Lice	1	1/			ess of Facility BOU					100/
			23a. Part1. Enter the disc s. or con	nolications that ca	used the death			AIN STREE			MARYL	AND Z.  Approximat	
Dhysia	ion (	9	234. Part1. Enter the disc s , or con shock, or heart faure List only Immediate Cause (Final			1.00	- 4					Interval Bet Onset and	ween
Physic /Medi	_		disease or condition resulting in death)		r as a consequ	ence of):	HEART	TA	<i>ILURE</i>	_		·····	
Exami	ner		Conversion to the tips and distance	. 2	ENAL	,	FAILUR	C				,	
g a	<u>.</u>	ner l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Sue to (d	or as a consequ	anca of):	A	_					
be executed sician and	-tran	Examiner	that initiated events resulting in death) Last	c	RONAP or as a consequ	ence of):	ARTEK	-7	)ISEAS	E			
760, te be ex ysician		CalE			us u consequ	31108 31).							
- 0 5	0			d									
BOX 08 1	esn	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			J=			23	d. Date of delive	ry	
Attending Physician: The law requires that the death certifical continues that the attending physician attending physician.	o per lo	Physician/Med	in the past 12 months?		th 2∏Fetal Intat time of de wn		Ectopic pregnancy Other (specify)	у			Month	Day ^	Year
hat the de			9 ☐ Unknown  Part II. Other significant conditions	contributing to dea	ath but not resu	lting in the ur	nderlying cause giv	ren in Part I	23a Did to	hacco use	e contribute to th	a cause of c	eath?
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he lay	bage z	E .	FIFERIER	231011					autop: perfor	sy med?	24b. Were autop prior to con death?		ause of
Vital Fician: The	ğ		25. Was case referred to medical					26. Place of Death		225 No	1 🗆 Yes	2 <b>X</b> No	
of V	ă .	0	examiner? 1 ☐ Yes _ 2 💢 No	Hospital: 1 🗆 In	patient 2 E	R/Outpatien	t 3 DOA Oth		-		☐Other (Specify	)	
on of ding Ph. After thi	nera li		27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury	Wor		28d. Describe h				
SiO tendi feath. tor: A	eu i	cat	2 Accident investigated 3 Suicide 6 Could not t	20				Yes 2 □ No					
Division of Vital Records, to attending Physician: The law requires the after death.  Director: After this certificate has been signer.	λο u	Certification;	4 Homicide determined	289. Flace (	of Injury - At hor g, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow		Number or Rural	Route Num	ber,
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director A	) III	<u> </u>	29a. Certifier 1 Certifying P	hysician: To the t	pest of my know	rledge, death	occurred at the tin	ne, date and place,	and due to the c	ause(s) a	nd manner as sta	ited.	
the Horin 24 the Fu	piete	Medical	one)	miner: On the bas	sis of examinati	on and/or inv	restigation, in my o	pinion, death occurr	ed at the time, o	late and p	lace, and due to	the cause(s	}
To the within 2 To the	100	2	29b. Signature and title of certifier				29c. Licens			9d. Date	signed (Month, L	ay, Year)	
<b>7</b>			Mohule	MI		MD		0060513	5	1/19	1/04		
IVA			30. Name and address of person who							/			
	State			4 Easterns	hore Dr.	Salist	pury, MD 21	804					
	State		31. Date filed (Month, Day, Year)	2004	President S Signate	JI 9	spark	2					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Lest) 3. Time of Death **Physician** ZEPHA HOWARD TINGLE 4b. City, Town, or Location of Deeth 1, 2004 4c. County of Death /Medical 5:05 PM 4e Fecility Neme (If not institution, give street end number) Examiner Salisbury Rehab and Nursing Center
5. Social Security Number 6. Sex 7. Age (In yrs. lest bir Salisbury, Md.
If Under 24 Hrs. 8. Date of Bi Wicomico If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) Date of Birth (Month, Day, Yeer) **Funeral** Days Months Hours Min. 1**⊠** M 2□ F 222-10-8069 Yrs. Director November 10,1922 Marvland Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Merylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits artment of Health end Mentel Hygiene. ortant: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show Injury or other traumstic event, the Medical Examiner must be nothined at 1 X Yes 2 □ No. Directo Wicomico Maryland Salisbury 10f Zip Code 10g. Citizen of What Country? 10e. Street end Number 200 Civic Ave. 21804 USA Funerai 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 No WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🐼 No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Marines 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator Tingle Music Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Be Zepha A. Tingle Stella Holloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health e Important: if item 27 is any injury or other tra Annabelle P. Tingle/wife 1001 Bayshore Court, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 1/13/04 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Composion CFSP 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical 9001-7 Examiner Due to (or as a consequence of): Examiner ettending physicien end for use es the bunel-trensit Attanding Physician: The law requires thet the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the completely filled in by the funeral director, page 2 should be deteched 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown ş 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1□Yus 2LTNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Hatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò To the Hospital 29a. Certifier 🕊 🗲 🚾 Tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UHIVA DE William H. Kobins, M. D 1346 S. Division St. Suite, Salisbury, Md. 21804 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State Registrar 2004 JAN 1 4

**DHMH 16 Rev 6/95** 

HOWARD TINGLE

			State of Marylar	nd / Depa	artment o		nd Mental Hyg	_	+ 03207
Physic /Med Exami	ical	Decedent's Name (First, Middle, Last)     SAMUEL JAMES     4a. Fecility Name (If not institution, give si	EDWIN	TODD	4b. City, Tow	n, or Location of	2. Date of Deal Month	Day Year  4c. County of De	2350 M
Funera Director		7- NINSULA REGIONA 5. Social Security Number 216-14-2875 6. Sex	1 Medical  M 2□ F 7. Age (In yrs.  92		If Under 1 Ye	SACISED Bar If Under 24 Bys Hours			Sirthplaca (State or Foreign Country) aryland
death with the Maryland me 23a or 28a-f ahow	Director	Usuel Residence of Decedent  10a. State 10b. County  Maryland Wicomico  10e. Street and Number		ity. Town or Lo		10		0g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ē 2 2	Funerai	423 Elberta Ave.	2. Was Decedent Ever in t Armed Forces? 1 Yes 2 XNo		218	SO1 of Hispanic Origi Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	USA 14. Race - Ar Black, W	mencan Indian,
filed within 72 hours after Hygiene.  Ather than "naturel", or ite man the man and a miner than a man a miner than a man a miner than a man a miner than a miner	Completed by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	If Yes, Give Year or Dates: ation completed) College (1-4or 5+)	163 Decer	dent's Usual Or		of working	Specify:	
Mally Idilia 2 12 13-0000 d 2 should be filed within 72 hours af th and Mental Hygiene. 7 is marked other than "naturel", or traumatic event, it a Modical Expan	To Be Cor	12 17. Father's Name (First, Middle, Last) Major handy Todd	-		t Capta	18. Mother	s Name (First, Middle, I	Maiden Sumame) Ores	tate" vessel
as 1 an of Heal		19a. Informant's Name/Relationship (Type William Truitt/Exe	ecutor 20b.	511 Place of Dispo		Rd., Sal	or Rural Route Number lisbury, MD Date		
parmit. Pages 1 a Department of Hee Importent: If Item any injury or othe		21. Signature of Funeral Service License	ntarbment Wic	22	morial P Name and A HOITOWA 501 Sno	dress of Facility	1/20/04 al Home Pro kd., Salisb	Salisbur fessional ury, MD 2	Association
Physiciar /Medica	_	23a. Part1. Enter the disease, or commisshock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the dea e cause on each line.  Due to (or as a conse	SEPS		dying, such as ca	ardiac or respiratory arn	est,	Approximate Interval Between Onset and Death 3 U
ate be executed any system and he burial-transit	ical Examiner	Sequentially list conditions, tary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	)				2 years
The taw requires that the death certificat are has been signed by the attending phypage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	□Ectopic pregn □ Other (specifi			23d. Date of o	delivery Day Year
w requires that the been signed by should be detact	þ	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	ndertying cause	e given in Part I.	11	es 2 1 No 3 1	to the cause of death?  Probably 4 □Unknown
UNISION OF VITAL MECONDS, for Attending Physician: The law requires that detector: After this certificate has been signed in by the funeral director, page 2 should be on the formal director, page 2 should be on the formal director.	Be Completed	25. Was case referred to medical examiner?				26. Place o	24a. Was a autops perform 1 Yes	prior t med? death 2 1 Y	autopsy findings available o completion of cause of ? es 2 \( \) No
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DIVISIC Ditel or Attence ours after death eral Director: filled in by the	Certification:	3 Suicide 4 Homicide  Could not be determined	28e. Place of Injury - At I building, etc. (Specialistics)	rify)			City or Town	n, State)	Rural Route Number,
To the Hospitel within 24 hours ( To the Funeral is completely filled	Medical	(Check only 2 Medicel Exemir one)  29b. Signature and title of certifier	ner: On the basis of examin and manner stated.	nation and/or in	vestigation, in a	my opinion, death cense number	occurred at the time, d	ate and place, and d	nth, Day, Year)
)		30. Name and address of person who co			Print)	04	USHA NATO	SAN, I	n. 9 .
S Regis	tate strar	31. Date liled (Month, Day, Year) JAN 16 20	ST, SALIS 32. Registrar's Sign 04	nature &	Spa	uks .			

216-14 2875

				For State Registrar	State o	f Maryla		artmen rtificate					Reg. No.	2004	03208	3
		Physici	20	1. Decedent's Name (First, Middle, La	ist)							2. Date of De Month	Day	Year	3. Time of Death	
		/Medic		CHRISTINE G. TRI				4h Cihi	Tours	r Location	of Doath	Janua		County of Deat		_
U	4	Examin	ier	4a. Facility Name (If not institution, gi			Wer	4b. City,		156016			40.	Wicon		
				PENINSULA REGIONA 5. Social Security Number 6.	Sex ///Eq.	7. Age (in yrs		) If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State or Foreign	n
	6	Funeral Director			1□M 2仄XF	63	Yrs.	Months	Days	Hours	Min.	02 <del>-</del> 10-1	940	WATE	RVIEW, MD.	
				Usual Residence of Decedent		40.0									10d. Inside City Limits	_
		arylar show	_	10a. State 10b. County			ity, Town or L								1 ☐ Yes 2 ☑ No	
		th the Marylan or 28e-f show	Director	MD WICOM	LCO	_   N	ANTICO	10f. Zip	Codo				10a Citi	zen of What Co	11	_
		death with the Maryland rms 23a or 28e-f show if must be notified at	Dir	10e. Street and Number	DO A D			218					rog. om	USA		
		ns 23	erai	20079 NANTICOKE	12. Was Dec	edent Ever in	U.S. 13.			lispanic Or	igin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race - Ame		
	(0	r lten	by Funerai	1 ☐ Never Married 2 ☑ Married	Armed Fo	2 X No		If Yes, spec				Rican, etc.)		Black, White	e, etc. /HITE	
	21215-0036	within 72 hours after ene. then "natural", or Ite ne Medical Examina	d by	3 Widowed 4 Divorced	If Yes, Gir Year or D	ve Pates:		TLITES	2 KM 1NO	эрвспу.						_
9	5-0	72 h natu	Completed	15. Decedent's E (Specify only highest g	ducation ade completed)		16a. Dec	edent's Usua e <i>kind of wo</i> DO NOT us	nk done	ation during mos	t of work	ing	16b. Kir	nd of Business/	Industry	
1-	121	within and the same.	m	Elementary/Secondary (0-12)	College (	1-4or 5+)		NSION					UNIV	ERSITY	OF MARYLAN	D
a.	2	e filed within al Hygiene. I other than vant, Ine Me	ပို	17. Father's Name (First, Middle, Las			1 21112	2102021			er's Name	First, Middle				_
1,	an	ld be ental ked c	To Be	RALPH GRAHAM						HILD	A SH	OCKLEY				
2	Maryland	should and Men marke umatic	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mai	ling Address	(Street	and Numb	er or Rur	al Route Numb	er, City or	r Town, State, 2	Zip Code)	
Mistra		es 1 and 2 of Health a f Item 27 le r other train		EDWARD A. TRICE	- SPOUSI					KE RC				ARYLAND		_
0	ore	of He		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3	Removal from		Place of Disp cemetery, cri	ematory or c	ther plac	ce)		Date		cation - City or		
3	Ĕ	nit. Pages partment of fortent: If Its injury or o		*4 □ Donation 5 □ Other (Spec	ify)	CR				1				AR, DEI		
3	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene, importent: If Item 27 ie marked other then "natural", or Items 23a or 28e-1 show morrism into 7 ie marked other then "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	Ho	4								HOME,	LAND 21804	
•		Pnysician /Medical Examiner		23a. Part. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on e	each liffe.	PTIC		le of dyir		cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death	
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743	3760,	ate be executed hysician and the buriat-transit	cai	resulting in death) Last	Due to	(or as a conse	equence of):							1		
8-06	). Box 68	To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2.⊟ No 9 ☐ Unknown		birth 2 ☐ Fe nant at time of	etal death 3	□Ectopic p □ Other (sp		4			1	23d. Date of del Month	livery Day Year	
112.	ls, P.O.	ires that the de signed by the a I be detached f		Part II. Other significant conditions	contributing to c		esulting in the	underlying o	ause giv	ren in Part	1.			1	o the cause of death?	'n
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	on of	ding Phy h. After this funeral d	ation: To	27. Manner of Death  1 Natural 5 Pending	28a. Date (Mor		28b. Time		28c. Injui Wo			28d. Describe			,	
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				I Robert B	all.	~ N	7.D		Da	916	8		1/	14/04		
		TAK		30. Name and address of person wh	o completed cau	ise of death (It	tem 23a) (Type	e, Print)								
	_	( MA		ROBERT B. A.	LEN, M	1.0	1346	5. 1	VISI	on	37.	SAL	15B	VAT, 1	MD 21804	<i>t</i>
		St Regist	tate trar	ROBERT B- A	5 2004	Registrat's Sig	gnature ,	G,	Spo	uls						

212-40-8743

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 2004 SARA TAYLOR 6, Jan 6:21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince Georges Hospital Cheverly Prince Georges tf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 579-30-5097 Feb.10,1918 85 Director S.Ĉ Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. toside City Limits show other traumatic event, the Medical Examiner must be notified at D.C. none Washington Y☐Yes 2☐No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3830 Blaine St. N.E. 20019 U.S.A. Items 23a by Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Btack, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant 1 ltem 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Educator 4 S.C.Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Agusta Wadsworth Mabel Stanley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorretta Taylor-Daughter 3830 Blaine St.N.E.Wash.D.C.20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition MD.Nat 1 Mem.Cem Jan.12,04 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel, MD permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hunt Funeral Home tromas 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARPIAC SUDDEN Immediate Cause (Final Priysician disease or condition resulting in death) /Medical HEATY DISCASE NSIVE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHROWIC ATRIAZ FIBRILLATION 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 2□ No 1 ☐ Yes 200No 1 Tyes or Attending Physician: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 P/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Maturat 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a

To the Funeral I

completely filled pelli Medical 1 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVI D. A. GORAY, MD, 1450 MCMCANTILE LN. LANGO, MD, 20774 82. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 3 2004 Registrar

MARYLAND PRINCE CEORGES MORNINGSIDE  100. Street and numbers  100. Stre				1 - For State Registrar	State	of Maryland / I		rtment of F tificate of		ind Mental	Hygie Reg.	200	4 03210
ANALYS OF J. 2004 1.100A P. 1.00 Ch. Town of Location of Dashin MONTCOMERY COUNTY TO THE PROPERTY OF THE PROPE		Physic	ian	Decedent's Name (First, Middle	, Last)							Day Yea	
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Special Secretary Number   1		Exami	ner			umber)							
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Use Parameter of December   100 City Town of Location										Min. (Month	Day, Ye	ear) 9. 8	Jountry)
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Security   Security	4	23 H	ai	6916 PICKETT DR	IVE			20746			UN	ITED STA	TES
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Security   Security	39	10	Ē		If Yes, G	2 □ No ive					,		
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Secretary   Secr	ر ا	2 1	lete	(Specify only highest	s Education f grade completed)	) 16a.	(Give ki	nd of work done o	durina most i	of working	16b	. Kind of Busines	s/Industry
Secretary   Secr	72	the the	E	Elementary/Secondary (0-12)						RK		FFDFRAL	COVERNMENT
WILLIAM TRIPP  192 Informatis Name/Pleating (Type, Print)  190 Mailing Address (Steel and Number of Path House Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190 Mailing Address (Steel and Number of Path Number, City or Town, State, Zip Code)  190	בו פו	t the		17. Father's Name (First, Middle, L			101	III RECOIL			idle, Maio		GOARIMIEMI
20. Author of Disposation and Plant School (Control Disposation of	<u>ם</u>	2 D 00	0 8	WILLIAM TRIPP							,	··,	
20. Author of Disposation and Plant School (Control Disposation of	Z S	mar met	-		ip (Type, Print)	19b	. Mailing	Address (Street a			mher Cir	tv or Town State	Zin Code)
Section   Sect	Š	1 C E		BARBARA TRIPP (	WIFE)								
MARVAILAND VETERANS CEM. 1/15/2004 CHELTENHAM, MD  21. Signaling of Physical Signature (Separations)  22. Signaling of Physical Signature (Separations)  23. Signaling of Physical Signature (Separations)  24. Signaling of Physical Signature (Separations)  25. Signaling of Physical Signature (Separations)  25. Signaling of Physical Signature (Separations)  26. Signaling of Physical Signature (Separations)  27. Signaling of Physical Signature (Separations)  28. Signaling of Physical Signature (Separations)  28. Signaling of Physical Signature (Separations)  28. Signaling of Physical Signature (Separations)  29. Si	ē, 2	f Hez item othe		20a. Method of Disposition	<del> </del>	20b. Place of	f Disposit	tion (Name of		1000	-		
23a Part Lifer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate prevail Between Chest and Death Che	ב ב			1XXSurial 2 ☐ Cremation  1 ☐ Cremation 5 ☐ Other (So	3 □Removal from ecify)	State			1	1/15/200		OTTET MENT	AM MD
23a Part Lifer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate prevail Between Chest and Death Che	# #	orte inju				n PARILE							
23a. Part I. Effer the disease, or completations that caused the each inc.    Part   Description   Part   Descript	n a	De la ga			larsh 1	X	MAH	RSHALL'S	FUNER	AL HOME	OF MA	ARYLAND,	INC.
Was decedent pregnant in the past 12 months?    1	ecuted III	Medical xaminer		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. ACUT Due to  c. ACUT Due to	(or as a consequence of the RESPIRAT (or as a consequence of the CHRONIC (or as a consequence of the CHRONIC)	CORY of): RENA of):		RE				
Was decedent pregnant in the past 12 months?    1	Sate O	physi the t	dica		d. CARI	DIAC ARREST	_						
1   Yes   2   No   3   Probably   XX   No   24a. Was an autopsy performed?   1   Yes   2   No   3   Probably   XX   No   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes   XX   No   2   No   No				23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live t 4 ☐ Pregr	oirth 2 Fetal death nant at time of death					-		•
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  XXNatural  28. Describe how injury occurred  28. Describe how injury occur	s that	ned b e deta	Y P	Part II. Other significant condition	s contributing to d	eath but not resulting in	the unde	erlying cause give	n in Part I.	23e. D	id tobacci	o use contribute t	o the cause of death?
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  XXNatural  28. Describe how injury occurred  28. Describe how injury occur		is na d blu	b b							1	□Yes	2 □ No 3 □ P	robably <b>XX</b> Unknown
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  XXNatural  28. Describe how injury occurred  28. Describe how injury occur	© %	s bae	olet							24a. W	as an	24b. Were a	utonsy findings available
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  XXNatural  28. Describe how injury occurred  28. Describe how injury occur	F 5	age (	E							— au	itopsy erformed?	prior to death?	completion of cause of
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and dadress of person who completed cause of death (Item 23a) (Type, Print)  KANWALJIT K. NAGI  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	ומן שויים		0	25. Was case referred to medical					Of Diagon			Vo 1 □ Yes	2 □ No
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and dadress of person who completed cause of death (Item 23a) (Type, Print)  KANWALJIT K. NAGI  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	slci <	s cer direct	0 0	examiner? 1 ☐ Yes XX No	Hospital:	Innatient 2   FR/Out	tnationt	3 DOA Othe	_		OF STREET	0 COtto (C	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and dadress of person who completed cause of death (Item 23a) (Type, Print)  KANWALJIT K. NAGI  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	2 g	er thi	2	27. Manner of Death	28a. Date	of Injury 28b. T	ime of		1 - 110.0				city)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and dadress of person who completed cause of death (Item 23a) (Type, Print)  KANWALJIT K. NAGI  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	ng in	ath. r: Aft	atio			tn, Day rear) In	njury						
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KANWALJIT K. NAGI  1500 FOREST GLEN RD. SILVER SPRING, MD 20902	DIVIS	after des i Director d in by th	ertifica		ed 286. Place	of Injury - At home, far ng, etc. (Specify)	rm, street	, factory, office	- 105	28f. Location City or	(Street a Town, Sta	and Number or Rite)	ural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KANWALJIT K. NAGI  1500 FOREST GLEN RD. SILVER SPRING, MD 20902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ne Hospite	n 24 hours he Funere pletely fille		[Silvedical Ca	Carringer. Off the Da	asis of examination and	, death or	ccurred at the time tigation, in my op	e, date and pinion, death	place, and due to the control occurred at the time	ne cause( e, date a	(s) and manner as nd place, and due	s stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KANWALJIT K. NAGI  1500 FOREST GLEN RD. SILVER SPRING, MD 20902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	To th	withii To th	ž	29b. Signature and title of certifier				29c. License	number		29d. D	ate signed (Mont	h, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KANWALJIT K. NAGI  1500 FOREST GLEN RD. SILVER SPRING, MD 20902  31. Date filed (Month, Day, Year)  32. Registrar's Signature		, 1		1 Conal	$\sim$	2:72 -		Don	562	62		1/0/	1.
KANWALJIT K. NAGI 1500 FOREST GLEN RD. SILVER SPRING, MD 20902  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	f	5	t	30. Name and address of person w	no completed caus	e of death (Item 23a)	Type, Pri	nt)	200	03	l'	1-110	7
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		0/							SI	LVER SPR	ING.	MD 2090	2
		Sta	te	31. Date filed (Month, Day, Year)	32. R								

SHIRLEY ANN VANRYSWICK

	1 - For State Registrar	Otato of Ma	ryland / Depa <i>Cei</i>	rtificate of L	Death	Reg.		4 0321
ian	Decedent's Name (First, Middle, Last     Shirley Ann Van R						Day Year 23 2004	N.
cal ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	JANUARI	4c. County of De	
	St. Mary's Hospit			Leonard			St. Ma	ry's
	212-02-1702	77	(In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye april 23, 1		rthplace (State or Foreig Country) ryland
_	Usual Residence of Decedent  10a. State 10b. County  Maryland St. Mary		10c. City, Town or Lo					10d. Inside City Limit
Director		8	Leonardt					1 ☐ Yes 2 <b>X</b> N
0	10e. Street and Number 21040 Hampton Roa	ıd		10f. Zip Code	0650	10g.	Citizen of What C	Country?
Funeral	11. Marital Status	12. Was Decedent En		Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	
by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	)	f Yes, specify Cubar □ Yes 2∏ No	Specify:	Hican, etc.)	Black, Wh	ite, etc. White
eted	15. Decedent's Edu (Specify only highest grad	ucation	16a. Deced	ient's Usual Occupa kind of work-done di	ation	166	. Kind of Busines	s/Industry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+	) life. L	DO NOT use retired)	)			
	12 17. Father's Name (First, Middle, Last)		H	omemaker	18. Mother's Name	e (First, Middle, Maid	wn Home	
To Be	William Douglas W	athen, Sr.				a Cecelia		
	19a. Informant's Name/Relationship (T)		19b. Mailin	g Address (Street a.		al Route Number, Cit		Zip Code)
	Leonard Van Ryswi	ck/Husband		Hampton	Road, Le	onardtown	, MD 206	50
	20a. Method of Disposition 1 Description 2 Cremation 3 F		20b. Place of Dispos cemetery, crem		1		Location - City o	r Town, State
	* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	T-T-T-	Our Lady			04 Leo	nardtown	, Maryland
	mechael Ker	Heiden	wh "	. Name and Address	P.O. B	cingley-Gard ox 270 Leona	iner Funer rdtown, M	Tal Home, P.A.
	23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line					1	Approximate Interval Between Onset and Death
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):  consequence of):  consequence of):	JER WI	TH NG	TASTASIS		MONTHS
-	IF FEMALE:	-		11.117-				
Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at til 9□Unknown	Fetel death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
by	Part II. Other significant conditions cor	ntributing to death but	not resulting in the un	derlying cause giver	n in Part I.	T		o the cause of death?
eted			7.00			1 Tes	2 LLH6 3 □ P	robably 4 Unknown
Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?	lospital:				(Check only one)		
1. 70	1 ☐ Yes 2 ☑ No ☐	1 Inpatient 28a. Date of Injury	2 ER/Outpatient	3 ☐ DOA Other 28c. Injury	4   Indising Hor	me 5 Residence 28d. Describe how in		icify)
5	1 Destural 5 Pending 2 Accident investigation	(Month, Day')	reer) Injury	Work?	es 2 No	Edd. Describe now in	jury occurred	
Ħ	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury building, etc.	/ - At home, farm, stre (Specify)	et, factory, office		28f. Location (Street City or Town, Sta	and Number or Rate)	ural Route Number,
ertification	4 Homicide				a, date and place	and due to the cause	(s) and manner as	
edical Certification:	29a. Certifier 1 Certifying Phys	sician: To the best of ner: On the basis of e and manner state	xamination and/or invi	occurred at the time estigation, in my opi	nion, death occurre	ed at the time, date a	ind place, and due	s stated. to the cause(s)
Medical Certification	29a. Certifier 1 Certifying Phys	iler. On the basis of e	xamination and/or invi	29c. License	nion, death occurr	ed at the time, date a	ond place, and due place signed (Mont	h, Day, Year)
	29a. Certifier 1 Certifying Physic (Check only one) 2 Medicel Exemin	and manner state	M D	29c. License	nion, death occurre	ed at the time, date a	and place, and due Date signed (Mont	h, Day, Year)

DHMH 17 Rev 1/2001

Registrar

AMES GIBBONS WOOD

			For State Registrar	State of M	larylan	d / Depa	artment c	of Heal	th and I	Mental Hy	giene 20	04	03213
	Obverio		1. Decedent's Name (First, Midd		-					2. Date of Dea	ıth		3. Time of Death
	Physici /Medi		Sharon	Kay Wal	renbu	ırg				January		reer	12:30 p.M.
	Examir		4a. Fecility Name (If not institution				4b. City, Tow	vn, or Loca	tion of Death	1	4c. County of		
			25725 Whiske 5. Social Security Number			last birthday)	If Under 1 Y		Lywood		St. M		
	Funeral Director		323-36-2963	1 M 2 F	PIN	Yrs.			urs Min.	(Month, Day		I. Birthpl	leca (State or Foreign try)
W.	ס		Usuel Residence of Decedent		60					Jan. 23	, 1943	<u> </u>	inois
	arylar show	يا	10a. State 10b. County	,	10c. City	, Town or Lo	ecation					10	Od. Inside City Limits
	he Mi	Director		t. Mary's				ywood	1				1 Yes 2 No
	with t		10e. Street and Number				10f. Zip Cod				log. Citizen of Wh	at Coun	try?
	Jeath	Funeral	25725 Whiskey	Creek Road  12. Was Decedent	Ever in U.	S. 13 '		20636		acify Vac or No.	United 14. Race -		
ထ	or Iter	Fun	1 Never Married 2 Mar	ried Armed Forces	?					pecify Yes or No- Rican, etc.)		White, e	
8	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2∰	No Spe	ecify:		Specify:	√hit	e
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. In the matural, or items 23a or 28e-f show event, the Medical Examiner must be incitied at	Completed		nt's Education est grade completed)		(Give	dent's Usual Oc kind of work do	one durina	most of worl	king	16b. Kind of Busin	ness/Ind	lustry
7	withir Bne. than	дше	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use re	ntired)			110 0		
מ ס		e Cc	17. Father's Name (First, Middle,	Last)		Irans	slator	18. M	Aother's Nam	e (First Middle	US Gove:		nt
<u> </u>	should be and Mental marked o urnatic eve	To Be	Robert Wahre							Veilmuen:			
ary	2 should be and Mental is marked of raumatic ev	-	19a. Informant's Name/Relations			19b. Mailir	g Address (Str				ster , City or Town, Sta	ate, Zip	Code)
Ξ	is 1 and 2 should if Health and Men item 27 is marke other traumatic		Malcolm J. Mur	phy / Husbar	d						lywood, I		
o O	of He fiter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		20b. Pl	ace of Disno	sition (Name or natory or other	<i>f</i>			20c. Location - Cit		
Ĕ	Pages ment of l ant: If it		' 4 □ Donation 5 □ Other (S	Specify)	ı	nsfiel	d-Echo1	Ls	1-10-	-2004	harlotte	Ha	11 MD
E E	permit. Pages Department of Important: If it any injury or o		21. Signature of Juneral Sentice	VC / S999		22	. Name and Ad	dress of F	acility Bri	nsfield	Funeral	Home	e. P.A.
_	0 0 7 8 Q		Edward N. Brins		M000	52   22	955 Hol	11vwo	od Roa	d. Leona	rdtown	MD 2	20650-0279
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on each I	d the death ine.	. Do not ente	er the mode of	dying, such	h as cardiac	or respiratory arro	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	-a. Gli	obla	Stor	na						Criser and Death
	Examiner			Due to (or as	a consequ	ence of):							
10-	200 201	Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Directo (or as	a consequ	enda of):							
	cuted	Examiner	Cause (Disease or injury that initiated events										
Ď.	e exection are in article.	Ex	resulting in death) Last	Due to (or as	a consequ	ence of):						-	
8/60	certificate be executed iding physicien and use as the burial-transit	dical		d									
×	entific ding p		IF FEMALE:	00-11						_			
X D	w requires that the death certific been signed by the attending p should be detached for use as:	hysician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3 🗌	Ectopic pregna				23d. Date of Month		y Day Year
j.	y the	iysic	1 □ Yes 2 □ No 9 □ Unkn <i>o</i> wn	4☐Pregnant a 9☐Unknown	time or dea	atn 5	Other (specify)	)			Wieridi	_	ray ( bai
7	The law requires that the ate has been signed by the page 2 should be detached.	0	Part II. Other significant condition	ons contributing to death t	ut not resul	ting in the un	derlying cause	given in Pa	art I.	23e. Did tob	acco use contribu	te to the	cause of death?
SDIOS	quires n sign	ed by								1 □ Ye	s 2□No 3[	Probal	bly 4 Unknown
္ဌ	aw re	piete								24a. Was ar	24b. Wen	e autoni	sy findings available
Ĕ	sician: The law certificate has b irector, page 2 s	Completed								autopsy perform	prior deat	r to comp th?	pletion of cause of
		BeC	25. Was case referred to medical	1 - 2 - 2				26. PI	lace of Death	1 Yes 2		Yes 2	∐ No
> 5	hysic his ce I direc	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 E	R/Outpatient	3□ DOA	Other			nce 6 Other (	Specify)	
5 = 5	ing P		27. Manner of Death 1 ■ Natural 5 ■ Pendin	28a. Date of Inju (Month, Da	ry y Year) 2	28b. Time of Injury	28c. In			28d. Describe ho		-	
<u>0</u>	tend death for: A	cati	2 Accident investig	gation				☐ Yes 2					
3	after Direction by	Certification:	4 ☐ Homicide determ		ury - At hom c. (Specify)	ne, farm, stre	et, factory, offic	æ		28f. Location (Str City or Town	eet and Number o State)	r Rural F	Route Number,
	spital ours neral filled		29a. Certifier 1 Certifyin	g Physician: To the best	of my know	ledge death	occurred at the	time date	and slage				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical (	Exeminer: On the basis of and manner sta	examinance	on and/or invi	estigation, in m	y opinion,	death occurr	ed at the time, da	use(s) and manne te and place, and	r as stat due to ti	ed. ne cause(s)
	To th Withir To th comp	mee .	29b. Signature and title of certifier					nse numb		29	d. Date signed (M	onth, Da	ay, Year)
			100	lle			Ma	55	75	/	1/9	10	4
1	+ son		30. Name and address of person	who completed cause of d	eath (Item 2	23a) (Type, P	rint)					•	
			Jennifer Schm	idt, D.O., 2	3415	Three	Notch I	Road.	Calif	ornia. N	ID 20619		
	Stat Registra	~ 1	on bato mod (month, bay, roar)	32. Registra	ar's Signatu	10		,			~~ <del>~~ ~ ~</del>		
Signal Signal	- icgistic		UMIN .	- W COU4	OR THE PERSON NAMED IN	A A	toute						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** January 17, 2004 Year Violet Williams 2:00am Loretta /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 895 Ocean Parkway Worcester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 1<sup>Y</sup>ear) August 1<sup>9</sup>, 1952 9. Birthplace (State or Foreign Country) Md. 6 Sex 7. Age (In yrs. lest birthdey) **Funeral** Days Hours 1 M 2 F 198-44-2676 51 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at pages. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Q Yes 2 □ No Md. Worcester Berlin 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 895 Ocean Parkway 21811 U.S. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry +2 College (1-4or 5+) Elementary/Secondary (0-12) Office Manager SeaHawk Motel 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Smith Allen Phyllis Audrey Price Green ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Price / Son 2009 Harbor Gates Dr. Apt.147 Annapolis,Md.21401 Allen 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State Robinson's cemetery 1/24/2004 Grasonville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover st. Easton, Md. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a Metostatic Corcinomo Examiner Due to (or as a consequence of): Examiner Aumio attending physicien end for use as the bunal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) resulting in death) Last signed by the a Id be datached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ been signated 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? pege 2 s 1 🗆 Yes 200 No 1 □ Yes 2 □ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ۵ 1 Yes 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) this oral Director: After thi filled in by the funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aftar of To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

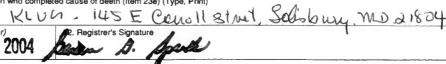
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30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

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			1 = State Registrar	State of Mary		epartment o		nd Mental Hyg	giene Reg. No. 20	04	03215
	Physici	an	1. Decedent's Name (First, Middle, Last)	Varehime				2. Date of Dea Month	ath Day	Year 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s University of Man	treet and number)			n, or Location of	Jan Death	4c. County of		
ei.	Funeral Director		5. Social Security Number 6. Sex 213-16-1907		97s. last birthe	(fay) If Under 1 Ye		Min. 8. Date of Birt (Month, Day June 9	, Yeer) 1922	9. Birthplac Country Mary	
	aryland show dat	Ļ	Usual Residence of Decedent  10a. State 10b. County		c. City, Town o					10d	. Inside City Limits 1 XYes 2 □ No
	n the Marrantile	Director	Maryland Carrol  10e. Street and Number			New W	indsor		10g. Citizen of Wh	nat Country	
	23a c	ralD	308 Maple Ave				21776			S.A.	
36	irs after dea	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Nidowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	r in U.S.	13. Was Decedent If Yes, specify (  1 ☐ Yes 2 🛣		n? (Specify Yes or No- Puerto Rican, etc.)	Bleck	- American , White, etc White	·.
Maryland 21215-003	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show aumatic event, the Medical Evanthar mutil be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		/(	ecedent's Usual Oc Give kind of work do ife. DO NOT use re	ne during most o tired)	of working	16b. Kind of Bus		
d 21	Hygier Hygier Ither th		17. Father's Name (First, Middle, Last)			seamst		s Name (First, Middle,	cloth		actory
ylan	m	To Be	Raymond H. Mille					Mary Ruth			
Mar	d 2 sh th and t7 ls m traum		19a. Informant's Name/Relationship (Ty) Carolyn A. Smith/d			Mailing Address <i>(Str</i> 03 Stone		or Rumal Route Number estminster			ode)
	s 1 and of Health Item 27 other to		20a. Method of Disposition		20b. Place of D	isposition (Name o crematory or other	place)	Date	20c. Location - C		n, State
altimore,	Pages iment of lant: If It iury or o		1 Ø Burial 2 ☐ Cremation 3 ☐ R  1 4 ☐ Donation 5 ☐ Other (Specify)		Pleasa	nt Valley	Cem. 1,	/17/2004	Pleasant	: Vall	ley, MD
Ball	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic as ODGS.		21. Signature of Funderal Service License	. Harze	en		rch St.	New Wind	sor, MD	21776	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the e cause on each line.						In	pproximate hterval Between enset and Death
	Physician /Medical		disease or condition resulting in death)	Duelo (or as a co	onsequence of	intracer	ebral	henorha	30		11 days
60,	cate be executed physician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of)					365	gears
68760	ificate g physias the	edicai									
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SYNo 9 □ Unknown	3c. If yes, outcome of p 1□Live birth 2 □ 4□Pregnant at tim 9□ Unknown	Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify			23d. Date Mont	of delivery h Da	ay Year
م	luires that the signed by ald be detail	by	Part II. Other significant conditions cor	tributing to death but n	ot resulting in t	he underlying cause	given in Part I.		obacco use contrib res 2 🗆 No 3	oute to the o	/
Division of Vital Records,		Completed						24a. Was autop perfor	rmed/? de	ere autopsy ior to comp ath? ] Yes 2[	y findings available letion of cause of
Viita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				of Death (Check only o	ne)		
on of	Phys this ral dii	lon: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	1 ☑ Inpatient 28a. Date of Injury (Month, Day Yo	2 ☐ ER/Outp 28b. Tin lnji	ne of 28c. i	Other: 4 Nurs		lence 6 Other		
Division	f or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farn Specify)				Street and Number n, Stete)	or Rural R	loute Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	Medical Co	29a. Certifier 1 Certifying Physical Check only 2 Medical Exemical	sician: To the best of more: On the basis of ex and manner stated	amination and/	death occurred at the or investigation, in n	e time, date and ny opinion, death	place, and due to the o	cause(s) and mani date and place, an	ner as state	ed. e cause(s)
	To the within :	Mec	29b. Signature and title of certifier	and manner stated	-	29c. Lid	ense number		29d. Date signed	(Month, De	y, Year)
)	6 90		Damy Jo	inf MO.		AUYIT	64350LIAN	6-15235	Janu	ary	13,2004
-	JUG XS		30. Name and address of person who co				6° 1	Q-11 ·		21201	
1/9	Sta	ite	Danny Liang, 12 31. Date filed (Month, Day, Year)	South D 32. Registrar's		with Greens	2 54. ,	Baltimore,	MD		
	Regist		ann o o	anna France	K	hoard !					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 13 January 2004 0832 M Edmand Wonilowicz /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hampstead 4484-1311 Woodsman Drive If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) August 5 1926 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1MM 2□F NJ 146-14-5937 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐XYes 2 ☐ No **Funeral Director** Hampstead Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21074 4484-1311 Woodsman Drive 12. Was Decedent Ever in U.S. Armed Forces? 1950 1⊠Yes 2 □ No If Yes, Give 1952 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Ifem 27 is marked other than "natural", or itel other traumatic event, the Medical Examination 1 Never Married 2X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify ģ 3 ☐ Wirlowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Chemical Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Zofia Saczkowska Ignacy Wojnilowicz ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4484-1311 Woodsman Drive Hampstead, MD 21074 Dorothy Wonilowicz/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1/23/2004 Pages 1 10 1 Durial 2 Cremation 3 Removal from State = 5 Department of Important: If any injury or once. Crestlawn Memorial Gardens Marriottsville, MD 4 □ Donation 5 □ Other (Specify) permit. 21. Signature of Funeral Service 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** dizozubrossilA /Medical Due to (or as a consequence of): Examiner voicuta Sequentially list conditions, Due to (or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Hicu burial-tran Due to (o \_\_\_\_\_onse uence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Dav Year in the past 12 mon Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown þ signad b d be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 2 🗆 No Completed . Were autopsy findings available prior to completion of cause of death?

1 \( \text{Yes} \) Yes \( 2 \text{\text{}} \) No 24a. Was an page 2 : autopsy performed has certificate 1 Yes 2 No Physician: completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Mesidence 6 Other (Specify) ٩ this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Certification: To the Hospital or Attending I within 24 hours after death. To tha Funaral Diractor: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 C Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral I Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) D9848. Peter Uggowitzer, MD completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso 4500 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State LELLY ... JAN 2 0 2004 Registrar

			1 - For Amend Item #	State of Ma 5 per fh G	ryland / Possession   Possessio	epartme 2/02 ta <i>Certifica</i>	nt of Hea S <i>e of De</i>	alth and M eath	ental Hy	giene Reg. No.	200	4 03217
	Dhuniai		1. Decedent's Name (First, Middle, Las						2. Date of De Month			3. Time of Death
	Physici /Medic		Willie Joe Wood						Janua	ry 1	7 2004	
\$	Examin	er	4a. Facility Name (If not institution, give					cation of Death		4c.	County of Dea	
			1896 Snydersburg  5-Social Security Number 6.8		(In yrs. last birth		stminst	Under 24 Hrs.	8. Date of Birl	h	Carrol	
	Funeral Director		242-70-4028 242-70-4228	M 2□F		Months		lours Min.	April	y, Year) 26	1946	thplace (State or Foreign ountry) NC
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Mary -f sh	į	MD Carrol:	1	Westm	inster						1 ☐ Yes 2X No
	or 286	Director	10e. Street and Number			10f. Z	p Code			10g. Citi	zen of What Co	ountry?
	death with the Maryland ms 23a or 28e-f show roust be notified at		1896 Snydersburg	Road			21157			Ţ	JSA	
5-0036	el', or Ite	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Education Armed Forces? 1 □ Yes ②□ Note of Yes, Give Year or Dates:		13. Was Dec		nic Origin? (Spe lexican, Puerto f pecify:	cify Yes or No Rican, etc.)		14. Race - Ame Black, Whit Specify: W	
ر م	22 99 33	etec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	1 (	Decedent's Us Give kind of w	ork done durin	n ng most of workir	na	16b. Ki	nd of Business	/Industry
7	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		life. DO NOT	ise retired)					
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Mary	id 2 should in and Men Men 27 Is marke treumatic	Ě	19a. Informant's Name/Relationship		19b.	Mailing Addres		Number or Rum				Zip Code)
	12 7 15 17		Sharon Lynn Wood					g Road				21157
Baltimore,	ite ite		20a. Method of Disposition  1 🍎 Burial 2 □ Cremation 3 □  1 4 □ Donation 5 □ Other (Specifi		20b. Place of I			1/227	2004		cation - City or	
Saltir	permit. Page Department Importent: If any injury or once.		21. Signature of Funeral Service Licer		Meadow	Pritts	Address of	Facility Tall Home	and Ch	ape]	stminst L, P.A.	er, MD
	40344		23a. Party. Enter the disease, or com	A Line in a course	ho doeth. Do so	412 Wa	shingt	on Road	Westn	unst	er, MD	21157
J	Physician /Medical		sh. or, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Son	consequence of	1 1		CAM	LOZ	rest,		Approximate Interval Between Onset and Death
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	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c.	consequence of	7-						
68760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	consequence of	):						
8	tificate ig phys as the	ledicai										
O. Box	at the death certificate be executed by the attending physician and trached for use as the burial-transil	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death	3 ☐Ectopic p 5 ☐ Other (s				2	23d. Date of de Month	livery Day Year
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00	iding F Ih. After funera	tlon	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Tii Inj	me of ury M	28c. Injury at Work? 1 ☐ Yes	2 🗀 No	8d. Describe h	now injury	occurred	
DIVISION	r Attenter dear	Certification;	3 Suicide 6 Could not be determined		y - At home, farr (Specify)				8f. Location (S City or Tox			ural Route Number,
	To the Hospitel of within 24 hours aft To the Funeret D completely filled in	edical C	29a. Certifier (Check only one)  Certifying Ph	ysician: To the best of niner: On the basis of e and manner state	examination and	death occurred for investigation	at the time, d	date and place, a on, death occurre	nd due to the dat the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	~ P. ~ ~ ~	1	29	c. License nui		_		signed (Mont	
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	3		m. PANSURIYA	349 ma	alcolm	DR Print)	We	strains	ster	10	10 21	157
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 0	2004 32. Registrar	's Signature	Spark	e					

			1 - For State Registrar	State of I	Maryland		artment <i>tificate</i>			and M		giene Jeg. No. 2 (	004	03218
T			1. Decedent's Name (First, Middle, Las	t)		7					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Margaret 1	Harner W	entz						January		004	3:45 a M
	Examin		4a. Facility Name (If not institution, give		er)				Location o			4c. County		2.7
			3369 Water Stree						ester				Carro	
п	Funeral		5. Social Security Number 6. So	9x 7. □M 2	Age (In yrs. la	st birthday) Yrs.	If Under	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	Year)		place (State or Foreign
	Director		166-12-4664 Usual Residence of Decedent	Λ	82						Jun 16,	1921	Pen	nsylvania
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Limits
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	or 28	Director	10e. Street and Number				10f. Zip					10g. Citizen of V		ntry?
	23e (23e)	ai	3369 Water Stree	t					21102				USA	
	r dea	Funerai	11. Marital Status	12. Was Decede Armed Force	es?	. 13. \	Was Decede f Yes, speci	ent of His	spanic Orio n, Mexican	gin? (Spe i, Puerto f	cify Yes or No- Rican, etc.)	14. Rac Blac	e - Americ k, White,	ean Indian, etc.
36	or I	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2: If Yes, Give 1 Year or Date	-		1 □ Yes 2	No No	Specify:			Specify	<i>/</i> :	white
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ta Madical Examena inual be modified at	edt	15. Decedent's Ed			16a. Deced	dent's Usual	I Occupa	ition			16b. Kind of Bu	usiness/In	dustry
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Importent: If item 27 is marked other than "natural", or flems 23e or 28e-f show any injury or other treumatic event, the Medical Examinating must be notified at ance.		19a. Informant's Name/Relationship (7 Harry Wentz, son	Гуре, Print)			•	,				r, City or Town, cer, MD		· ·
	1 and 1ealth 9m 27 ther t		20a. Method of Disposition		20b. Pla	Ice of Dispo			II VOC		ate	20c. Location -		
סר	Ages or of P		1 ⊈Burial 2 ☐ Cremation 3 €		ate cer	metery, crer	natory or ot	her place			100			
Baltimore,	artmer artment ortent injury		*4 □Donation 5 □ Other (Specify  21. Signature of Fundal Service Licen		M00723	· · · · · · · · · · · · · · · · · · ·	. Name and				3/2004			wn, PA
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ion	nding th. :: Afte	atio	1 Natural 5 Pending 2 Accident investigation		Day Year)	Injury	М		? /es 2 □!	No				
Division of Vital Records,	Atte	iffice	3 Suicide 6 Could not be determined	286. Place of	Injury - At hon	ne, farm, str	eet, factory,	, office		2	28f. Location (S City or Tow	treet and Numb	er or Rura	l Route Number,
Ö	rs after or rs after or rel Dis	Certification;												
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 ∠Certifying Ph (Check only 2 ☐ Medicel Examone)		is of examination									
	o the	Mec	29b. Signature and title of certifier	/	. 3,0,30.				number			29d. Date signe		
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	JES .		30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print)						2.	12:-
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	Regist	rar	JAN 2 0	ZUU4 X	A RELAK	13	A PRINCE	1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Death Day **Physician** 1/9 /04 JAMES WHITE 11:55 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Death SALISBURY WICOMICO 900 JAMES CT If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day Year) Birthplace (State or Foreign MD Country) 6. Sex **X**□ M 2□ F **Funeral** Days 74 Yrs. Director 213-22-9922 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Depertmant of Health and Mantel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, the Madical Examinar must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits X□ Yes 2□ No Funeral Director WICOMICO SALISBURY MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 900 JAMES CT. USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Vas Give <u>م</u> 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cglege (1-4or 5+) AUDITOR STATE OF VA. 18. Mother's Name (First, Middle, Maiden Surname) MARY JONES 17. Father's Neme (First, Middle, Lest) Be EARL WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 900 JAMES CT. SALISBURY, MD 21804 SARA WHITE WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State NGHILL METERY 1/17/04 SALISBURY,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MESSICK FUNERAL HOME PO BOX 61 M00416 BIVALVE, MD 21814 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted ig physician and as the burial-trensit 100000V3 Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of): attanding p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. bean signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? paga 2 s certificata has 1 Tes 2 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: aftar death. e 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Netural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0,0 A02031 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) Robert Branton 1205 D-. 50.0 31. Date filed (Month, Day, Year) 32. Registrer's Signature State JAN 1 5 2004 Registrar

			1 - For State Registrar	State of Ma	arylan		artmer rtificat					giene	2001	. 03	220
			Decedent's Name (First, Middle, Lands)	ast)							2. Date of De			3. Time	of Death
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	/Medic		4a. Fecility Name (If not institution, gi	ve street and number)			4b. City.	Town, or	Location of	of Death	01		County of Dea		Α "
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	<b>-</b>		GOLDEN GARDENS, 78 5. Social Security Number 6.			last birthday)		r 1 Year	If Under		8. Date of Bir (Month, De			thplace (Stete ountry)	or Foreign
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	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits
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	28a	Director	10e. Street and Number		0111	SIBBOR	10f. Zip	Code				10g. C	tizen of What C	ountry?	
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	na 2	era	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.			spanic Ori	gin? (Sp	ecity Yes or No Rican, etc.)	)-	14. Race - Am		
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9	be filed within 72 hours after death with the Maryland that Hygiene.  do other than "natural", or itema 23a or 28a-f ahow event, the Medical Exprine miss motified at	Completed	15. Decedent's E	ducation		16a. Dece	dent's Usu kind of wo	al Occupa	tion	t of work	ina	16b. k	(ind of Business	/Industry	
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Maryland 21215-0036	" = = =		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	S (Street a	and Numbe	er or Run	al Route Numb	er, City	or Town, State,	Zip Code)	
	and 2 saith a n 27 is		WANDA DAWSON - NI	ECE		8825	HICK	ORY 1	MILL	RD.	SALISBU	JRY,	MARYLA	ND 2180	01
Baltimore,	of Hea of Hea fitam		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of other place	9)	1	Date	20c. L	ocation - City or	Town, State	
Ē	permit. Pages Department of Important: If it any injury or o		1 N Burial 2 □ Cremation 3 i 1 Other (Spec		1	RINGHI	•	-		1-17	-2004	HEB	RON, MA	RYT.AND	
at:	artm orta inju		21. Signature of Funeral Service Lice	ensee									L HOME,		
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<u>α</u>	The law requires that the site has been signed by th bage 2 should be detache		Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	nderlying (	cause give	en in Part I		23e. Did t	obacco	use contribute t	o the cause of	death?
ds	uires sign	d by	ASCUP								1 🗆	Yes 2	<b>S</b> No 3 □ P	robably 4	]Unknown
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying F (Check only 2 Medicel Exa	hysician: To the best aminer: On the basis o	f examina	tion and/or in	n occurred vestigation	n, in my op	ie, date an pinion, dea	nd place, ith occur	and due to the red at the time,	date an	d place, and du	s stated. e to the cause	(s)
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	ILA		30. Name and address of person who	completed cause of c		n 23a) (Type,	Print)	in N.	ULFE	DEL	57.8	3ck	BURY /	1021	801
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Jan. 2004 WINSTON H . /Medical EDNA 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Nanticoke, Md Under 1 Year If Under 24 Hrs. AT HOME 20530 Mockingbird Lane
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Wicomico 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🙀 F WyOming 11/8/1919 84 Director 126-10-8596 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location TIS 23a or 28a-f show 1 □ Yes 2 □ No Wicomico Nanticoke Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ᅙ 21840 U.S.A. 20530 Mocking Bird Lane Funerai 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural, or Itel ry or other traumatic event, the Medical Exercites 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home House Wife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Melvina Brodine Edward Hill 19a. Informant's Name/Relationship (Type, Print)

Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6704 Fairfax Rd, Chevy Chase, Md 20815 Elizabeth Tordellã, permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ➡Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Fort Lincoln Cem Brentwood, Md 21. Signature of Funeral Service Licensee M00-416 22. Name and Address of Facility

Messick Funeral Home, Bivalve Mossus P.O. Box 61 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Commony /Medical Due to (or as a consequence of Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last work Examine The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician and ned for use as the burial-tran Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 this certificate t 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification; 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Letifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier o.a. andens Hasash 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1205 Pamberles Da. 15. 100 31. Date filed (Month, Day, Year) JAN 13 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Carol Ann Whatley 7:10 P M 2004 20 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Haure De Grace Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 27, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🛱 F 60 261-64-0282 Yrs. 1943 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show treumatic event, the Modical Examinar must be notified at Havre De Grace 1 XYes 2 No MD Harford Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 415 S. Market Street 21078 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bartender Hospitality 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is 1 and 2 should be file. Health and Mental H tem 27 Is marked oth Kathleen Crowley Fred Beck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Juportant: If item 27 Is many injury or other ones. 208 Rowland Road, Port Deposit, MD 21904 Tina Baldwin/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date R.T. Foard Funeral Home, P.A. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rising Sun, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R.T. Foard Funeral Home. P.A. 111 S. Queen Street, Rising Sun, MD 21911. 21. Signature of Funeral Service Licenses ichano 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition a. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to ( as a consequence of): Offenic obstructive lung Examiner KIEMOMION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached t 1 ☐ Yes 2 ☐ No 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ res 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 **D** No 1 Yes 25. Was case referre to medical Be 26. Place of Death (Check only one. examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 D No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Whatley, Caro

within 24 hours efter o

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

406

MY

29d. Date signed (Month, Day, Year) 04 21

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar JAN 2 3 2004



State

			For State Registrar	State of	Maryland		artmen rtificate			and M		giene Reg. No.2	004	03223
I	Dhusisi		1. Decedent's Name (First, Middle, L	-							2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio		Alphonso Sylve	ster Jose	eph Wilk	kinso	n.				Janu			5:20 P. M
4	Examin	er	4a. Facility Name (If not institution, go	ve street and numb	oer)				Location of	of Death			unty of Death	
			Sunbridge Care					kton	If Under	24 Hrs	9 Date of Birt		ecil	None (State of Familia
	Funeral Director		5. Social Security Number 6.  579-24-2530 Usual Residence of Decedent	Sex 1☐M 2☐F	Age (In yrs. las	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da 2/17/2	y, Ye <i>ar)</i> 5	Cour	place (State or Foreign htry)
	land ow		10a. State 10b. County		10c. City,	Town or Lo	ocation						1	Od. Inside City Limits
	Mary	ţō	D.C.			Wash:	ingto	n						1 X Yes 2 □ No
	r 288	Director	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What Cour	ntry?
	15 wit	aiD	4518 Eads St.,	N.E.						019			U.S.A	Α.
	ems	ner	11. Marital Status	12. Was Deced Armed Forc	es?	. 13.	Was Deced	ent of His	spanic Origin, Mexican	gin? (Spe i, Puerto	cify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,	
36	or it	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 If Yes, Give	:□No es: <b>'43</b> - <b>'</b> 4		1 ☐ Yes		Specity:				ecity: Bla	ack
Ş	d within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Madical Examinat must be notified at		15. Decedent's I				dent's Usua	al Occupa	ition			16b Kind	of Business/In	
5.	S 3	piet	(Specify only highest g	rade completed)		(Give	kind of wor DO NOT us	rk done d	lurina most	t of worki	ng	700.74.70	o, 200,1000 11.	333.17
21215-0036	filed within Hygiene.	Completed	Elementary/Secondary (0-12) 8th	College (1-4	(Or 5+)	Co	ok				_	U.S	. Gove	rnment
힏		Bec	17. Father's Name (First, Middle, Las								(First, Middle,	Maiden Su	mame)	
<u>Ja</u>		2	Alphonso Sylves	ster Wilk:	inson				Н	azeı	Tyler			
Maryland	d 2 sh th and th and 17 ls m traum		19a. Informant's Name/Relationship Eugenia Millice		nson/Wi:	19b. Maili fe	ng Address 4518	(Street a Eads	st.,	N.E.	, Washi	n, City or To .ngton	own, State, Zip	20019
Baltimore,	ges 1 an t of Heal If item 2 or other		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from St	cen	ce of Dispo	osition (Nam matory or o	ne of ther place	9)	С	ate	20c. Locat	ion - City or To	own, State
Ë	Pages tment of t tant: If it jury or o		4 □ Donation 5 □ Other (Spec	ify)	Che						1/14/0	В	eltsvi	lle, Md.
Bal	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lice	W. 5	160	4	<u>925 B</u>	Wash urro	ingto ughs	n & Ave.	Sons Co	lash.,	D.C. 20	0019
			23a. Part1. Enter the disease for con shock, or heart failure. List on	mplications that cau	used the death. th line.	Do not en	ter the mod	e of dying	g, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a	evven	tra								Onsor and Doam
	/Medical Examiner		resulting in death)	Due to (or	as a conseque	ence of):	1	7.	2/.					
н		-	Sequentially list conditions,	b. Due to (or	as a conseque	ence of):	a	050	vou	V		ſ		
	uted J ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	molo	ra ir	TAL	ule	1	011	poli	in		
oʻ.	exect an and rial-tra	Exa	resulting in death) Last	Due 10 (or	a a con eque	ence of):	0-19-0				200			
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	cai	,	d. AF	enos	clon	otie.	Ca	relie	ca	sula	or d	Islav.	1C.
9	ng ph as th	Jed	IF FEMALE:	MA										
Вох	leath certifica attending ph I for use as the	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregnand th 2 Petal d		∃Ectopic pr	egnancy				23d	. Date of delive Month	ery Day Year
о: П	the all	Physician/Medical	1 Yes 2 No	4□Pregnar 9□Unknow	nt at time of dea vn	ith 5	Other (sp	ecify)						
<u>α</u>	that the de ted by the detached		Part II. Other significant conditions	contributing to dea	th but not result	ting in the u	inderlying c	ause give	n in Part I.		23e. Did to	obacco use	contribute to the	ne cause of death?
Vital Records,	P P P	d by									101	res 2 DA	o 3 □ Prob	eably 4 Unknown
Ö	w requir been s should	lete									24a. Was	an 2	4b. Were auto	psy findings available
Re	o _ o	Completed									autop perfo	rmed?	prior to con death? 1 ☐ Yes	mpletion of cause of
ţ	lan: The rtificate stor, pag	0	25. Was case referred to medical						26. Place	of Death	(Check only o		, 🗀 103	2010
Ž	ysic is ce direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 Ing	patient 2 El	R/Outpatie	nt 3 DC	)A Othe	n 4 Wu	rsing Hor	ne 5 Resid	dence 6 □	Other (Specif	y)
n of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	Injury 2 Day Year)	28b. Time o Injury	of 2	8c. Injury Work	at ?		28d. Describe t	now injury o	ccurred	
Sio	Attending r death. ector: After by the fune	catic	2 Accident investigati				М	1 🗆 Y	/es 2 □ I					
Division	of or Attency after death Director: d in by the f	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 286. Place o	f Injury - At hom g, etc. <i>(Specify)</i>	ne, farm, st	reet, factory	, office		1	28f. Location (5 City or Tox	Street and N vn, State)	lumber or Rura	I Route Number,
-	To the Hospital or within 24 hours after To the Funeral Directoryletely filled in b			hysician: To the b										
	the Ho hin 24 I the Fu npletely	edical	(Check only 2 Medical Expone)	aminer: On the bas and manne	or stated.	on and/or in	ivestigation	, in my op	oinion, dea	th occurr	-			
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	0	111	)	290	License	number	6	(	29d. Date	igned (Month,	Day, Year)
7			1 1/	Tu	100		11	16	06		1	- 7	40	-
	(V)		30. Name and add - s of p- on wh	completed cause	of death (Item 2	23a) (Type,	Print)	SH	- lac	UTY	e do e	Trac	e N	IP,
	Sta	ite.	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signatu	Ire a		-	· Mo	0 1	- 00	V/-	21	678.
	Regist		JAN 1 2 2004	Kenny	H.	Specific							- 0	

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Month Day Year 30 HW w. aymond OH 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility-Name (If not institution, give street and number) 11700 Center ale If Under 24 Hrs. if Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Sex 1 M 2 ☐ F Days Hours Months 3/1903 Yrs. N. Brentwood, Md. 101 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 □ No Washington D.C. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20019 3318 N St., S.E. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐xNo Specify: Black Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Industry Maintenance Worker 7th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Martha Johnson James Vernon Wallace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3318 N St., S.E., Wash., D.C. 20019 Otelia W. Mugg/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nat'l. Mem. Park 1/17/04 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee H.S. Washington & Sons Co., Inc. 20019 WU 4925 Burroughs Ave., N.E., Wash., D.C. 23a. Part1. Enfer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? THEON IC OISSTRUCTIVE LUNG LIGHT 2 0 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Attending Physician The law requires that the death certificate be executed physician and Division of Vital Records, P.O. Box 68760,

Examine Physician/Medicai δ Completed Be Certification: To

**Physician** 

/Medical

Director

Funeral

à

Completed

Examiner

**Funeral** 

Director

Peges 1 and 2 should be filed within 72 hours after deeth with the Marylenc

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at

nd Mental Hygiene.

nt of Health and : If item 27 is r

Department of important: If any Injury or phose.

**Physician** /Medical

Examiner

filled in by the funeral director deeth. s efter deeth

To the Hospital of within 24 hours of To the Funeral Dicompletely filled in

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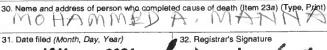
29a. Certifier

3 Suicide

31. Date filed (Month, Day, Year) 2004

29b. Signature and title of certifier

6 Could not be determined



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

	•	For State Registrar	State of Man	yland /				ealth a Death	and M		giene Reg. No. 2	004	03	225
	100	1. Decedent's Name (First, Middle, Las	t)							2. Date of De Month	ath Day	Year	3. Time	of Death
Physicia /Medic		Gladys Mae W	right							Januar	y 10	2004	2:3	32 A M
Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death		4c. Co	ounty of Deat	th	
		Doctors Community	Hospital				nhan				Pri	nce Ge	orge's	3
Funeral		5. Social Security Number 6. S	7. Age (	In yrs. last b		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Nov . I	h Y Year)	9. Birt	thplace (State ountry)	or Foreigi
Director		212-36-3290	LIM ZUM	64	Yrs.					Nov. I	8,193	9 Mar	yland	
pur *	-	Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, To	wn or Loc	ation							10d. Inside	City Limits
sho	5	MD Prince G		Bow									1 <b>☐XY</b> e	s 2 No
the N	ect	10e. Street and Number	eorge 3	DOW	110	10f. Zip	Code				10g Citize	n of What Co	ountry?	
with a or	Funeral Director	12204 Rustic Hill	Drivo			101.2.0	207	715				USA	,	
eath	eral	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. W	as Deced			ain? (Sp	ecify Yes or No	- 14.	. Race - Ame	nican Indian,	
ter d	5	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 ☐ No							ecify Yes or No Rican, etc.)		Black, Whit		
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J within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-1 show the Madical Examinar must be notified at	Completed	15. Decedent's Ed	lucation	16	a. Decede	ent's Usua	I Occupa	ition	t of work	ing		of Business/		
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of Hes of Hes fitem r othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State		tery, crem	atory or o	ther place			Date	_	tion - City or		
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permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licen	11							all Fur				
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The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal dea		Ectopic pr Other <i>(sp</i>					230	d. Date of dea Month	livery Day	Year
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To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	edical	(Check only 2'   Medical Exar	ysician: To the best of niner: On the basis of e	xamination a	lge, death and/or inv	occurred estigation	at the tim	e, date an pinion, dea	id place, ith occuri	and due to the ed at the time,	cause(s) ar date and pi	nd manner as ace, and due	s stated. to the cause	a(s)
To the He within 24 To the Fu completed	Med	one)	and manner state	od.				number						
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		Rointan Farahii				gia A	ave.	Sil	ver	Spring,	MD.	20908		
Sta Registr		31. Date filed (Month, Day, Year) 1 3 2004	2. Registrar			-								

			For State Registrar	State of	Marylan	•	artmeni rtificate			and M	-	giene Reg. No.	200	)	03	1226
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Ş	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23s or 28s-f show that the Medical Examerat must be profiled at	Completed by Funeral Director	15. Decedent's	Year or Date	s:	16a. Dece	dent's Usua	I Occupa	ation		1	16b. Kir	nd of Busine	ss/Ind	ustry	
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Mai	d 2 st th and 7 is n		19a. Informant's Name/Relationshi  Janice Bauer / 6				Lake:				Bowie, M			e, zip (	J00 <del>0</del> )	
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Baltimore,	그 문문 등		21. Signature of Funeral Service L		4	22	. Name and	d Addres	s of Facilit	у Ве	all Fun	eral	Home			
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760,	Physician /Medical Examiner    We private and private transit    Physician and private transit    P	ical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last	a		uence orj:	2 41	ve	Hee	rt	Fail	ur	e		Interval Be Onset and	
O. Box 68	the death certific yy the attending p ached for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ੴNo 9 ☐ Unknown	23c. If yes, outcor 1  Live birth 4  Pregnant 9  Unknown	2 Fetal	death 3	Ectopic pre					2	3d. Date of Month		y Day	Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant condition Cerebro van				nderlying ca	iuse give	en in Part I.		23e. Did to	_	se contribut ]No 3 [			
Ö	s beer	Completed	Chronic	Obstruc	tive	Leur	Din	eur	e		24a. Was a		24b. Were	autop	sy findings	s available
	The lav	шо	Hypercho			,					autops perfor	med2- 2 No	death	1?	pletion of a 2□ No	cause or
<u> </u>		Bec	25. Was cas referred to medical examiner?	37-10					26. Place	of Death	(Check only or					
<u>&gt;</u>	Physic this ce al dire	2	1 □ Yes 2 12 No	Hospital: 1 🗌 Inpa		ER/Outpatien		A Othe	ar: 4□Nu		ne 5 Nesid			Specity)		
Division of Vital	Atending P death. ctor: After t y the funera	ation:	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	ition	njury Day Year)	28b. Time of Injury	M 28	3c. Injury Work 1 🗀 Y	at ? ∕es 2 □ l		28d. Describe h	ow injury	occurred			
	in b	Certification:	3 Suicide 6 Could no 4 Homicide determin	building,	etc. (Specify	v)					28f. Location (S. City or Tow	n, State)				mber,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be xeminer: On the basis and manner	of examinat	wledge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date an inion, dea	d place, a	and due to the c ed at the time, d	ause(s) a late and	and manner place, and o	as sta du <b>e</b> to t	ted. he cause(	(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier						number				signed (M		•	
	0			Year to			-						/13/			
_	(5)		30. Name and address of person w	to completed cause of	f death (Item	(Type,	Print)	4 (	bre	eui	belt, o	MP	20	770	9	
ite ada	Sta Registr		31. Date filed (Month, Day, Year)  JAN 1 A 20	Z. negi	stial a digita	ture										

			1 - For State Registrar	State of Ma	-	oartment e <i>rtificate</i>			and Mo		giene Reg. No.	2111	) [;	03227
	Physici /Medic		1. Decedent's Name (First, Middle, La		NOCOLA	ND				2. Date of De. Month	Day OS	? 0	ar L	3. Time of Death 1403 PM
)	Examin		4a. Facility Name (If not institution, given the COLT WASHTNG	TON HOSPI			· W.		N67	ON, ME	P		GE	ONGE'S
i i	Funeral Director			Sex 7. Age	(In yrs. last birthda 57 Yrs.		Days	Hours	Min.	8. Date of Bin (Month, Da July 12	y, Year) 2,194	6 W	Countr	ce (State or Foreign y) Lngton, D.C.
	se Maryland 8a-f show	Director	10a. State 10b. County Maryland Prince	Georges	10c. City, Town or Accokee	k								d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with ti		10e. Street and Number 714 Manning Rd.	East		10f. Zip C	;oae 0607					zen of Wha Lited		
5-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other than "natural", or items 23a or 28a-f show imalic event, the Mudical Exercities mail be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 梵Yes 2 □ No If Yes, Give Year or Dates: {	ver in U.S. 13 8/24/66 8/23/68	3. Was Deceder if Yes, specify		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	-	14. Race - / Black, V Specify:	America Vhite, et	n Indian, ic.
21	within 72 ho ane. than "natur	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 1 2		(Gin life	edent's Usual ve kind of work DO NOT use	done di retired)	uring most	of workin	g		nd of Busin		
aryland 21	ed al be	To Be Cc	17. Father's Name (First, Middle, Last Stayman Thompson					18. Mothe		(First, Middle,	Maiden	Sumame)	ment	
≥	nd 2: ulth ar 27 is r trau		19a. Informant's Name/Relationship Sandie D. Woodla		1	iling Address (S	Rd		st Ac		, Md.	. 20	607	
Baltimore,	t. Page rtment o rtant: if njury or		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special Country)	(y)	Maryla	nd Vete	er place eran	s Ja	an.21	,2004	Che1		m, M	
Ba	Depa impo any ic	V. S	21. Signature of Funeral Service Lice	aray of 01		22. Name and Alexan 5538 M						es Md		20747
	Physician /Medical		23a. Part1. Ehter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	. ACUTE	E MYOU						rrest,		ı	Approximate nterval Between onset and Death
3760,	Examiner	Ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. SEVER Due to (or as a	consequence of):	7C RE	EGU	LRGI	TAT	nan			\(\)	10 Minuiles fears
P.O. Box 6	Attanding Physician: The law requires that the death certificate be executed rideath.  sctor: After this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Petal death 3	B⊟Ectopic preg					2	3d. Date of Month		y Day Year
	w requires that been signed b should be deta	Ď	Part II. Other significant conditions  UN STATSUE	eontributing to death bu	t not resulting in the	underlying cau	ise give	n in Part I.			obacco u Yes 2 Ç			cause of death?
al Records,	: The law requicate has been ; page 2 should	Completed								24a. Was autop perfo 1 Yes	rmed?	24b. Were prior deat	to comp	sy findings available pletion of cause of
Ž	sician s certif lirecto	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 A ER/Outpati	ent 3 DOA	Othe	-		(Check only only only only only only only only		Other (	Snacity)	
Division of Vital	nding Phy ath. r: After this e funeral c	ertification: T	27. Manner of Death  1  Natural 5  Pending 2  Accident investigated	28a. Date of Injury (Month, Day	28b. Time		c. Injury Work		2	8d. Describe I			эроспу	
Divis	i Sign	Certific	3 Suicide 6 Could not l		ry - At home, farm, : . (Specify)	street, factory,	office		2	8f. Location (5 City or Tox			r Rural I	Route Number,
	To the Hospitel within 24 hours of To the Funeral Completely filled	Medical		hysician: To the best of miner: On the basis of and manner stat										
)	To th within To th comp	Me	29b. Signature and title of certifier	mare	examination and/or red.  MD  path (Item 23a) (Typ)  TILLVIA  r's Signature	29c. I	License	number			29d. Date	signed (M	fonth, Di	ay, Year)
2	(7)	9	30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ	e, Print) OSTAN	Rd.	Ft	Wast	ringter	1, MD	207	44	
	Sta Regist		31. Date filed (Month, Day, Year) JAN 1 4 2004	32. Registra	r's Signature	و مجار								

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Marylan		ent of Health and ate of Death	i Mental Hy	giene 200	4 03228
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last)	lans		T	2. Date of De Month	Day Sear	3. Time of Death
	Examin Funeral Director	er	5//-54-8106	. 11	mi je	y, Town, or Location of De  Work  Ier 1 Year   If Under 24 H s   Days   Hours   Mi	1 ADAC		thrighton bearing the control of the
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show environment: If Item 27 is marked other than "natural", or items 23a or 28a-f show environment or other traumatte event. It a Maryland Examinant and item colling a gone.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  District of Columbi  10e. Street and Number  3529 21st St SE  11. Marital Status  1 Never Mamed 2 Married  3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12)  Twelve  17. Father's Name (First, Middle, Last)  James Walls  19a. Informant's Name/Relationship (Typ.  Diane Williams/Daug  20a. Method of Disposition  1 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	2. Wes Decedent Ever in U Armed Forces? 1   Yes 2 M No If Yes, Give Year or Dates: ation completed) College (1-4or 5+)  De, Print) ghter amoval from State Mt	S.   13. Was Dec   17 Yes   1	Management  18. Mother's N  Katie I  ss (Street and Number or the St SE Wash)  lame of rother place)  January (18. Mother's N  Katie I  January (18. Mother's N  Katie I  January (18. Mother's N   January (18. Mother's N   January (18. Mother's N   January (18. Mother's N   January (18. Mother's N   January (18. Mother's N   January (18. Mother's N   January (18. Mother's N   January (18. Mother's N    January (18. Mother's N    January (18. Mother's N    January (18. Mother's N    January (18. Mother's N    January (18. Mother's N    January (18. Mother's N    January (18. Mother's N    January (18. Mother's N    January (18. Mother's N    January (18. Mother's N     January (18. Mother's N     January (18. Mother's N     January (18. Mother's N     January (18. Mother's N     January (18. Mother's N      January (18. Mother's N       January (18. Mother's N        January (18. Mothe	Spec ame (First, Middle Mae Polla Rural Route Numb Lington, D Date Lary 17, 04 Debert G.	Isb. Kind of Business U.S. Bureau ing and Promote Ard  or, City or Town, State, C. 20020 20c. Location - City or Washington Mason Funer	Ates  arican Indian, te, etc.  Lack  Andustry  of Engrav-  Inting  Zip Code)  Town, Stete
3760,	ate be executed  /Medical Examiner  the burial-transit	ical Examiner	23a. Par1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	phe to (or as a conseq	ended unice of ):	ode of dying, such as card	ac or respiratory a	irest,	Approximate Interval Between Onset and Death
.O. Box 68	death certific e attending p od for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Sc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3 Ectopic			23d. Date of de Month	livery Day Year
Records, P.	The law requires that the de ite has been signed by the a page 2 should be detached	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	cause given in Part I.		obacco use contribute to Yes 2 □ No 3 □ Pr	the cause of death?
	The lay ate has page 2	Completed					1 ☐ Yes	psy prior to death? 2 1 Yes	utopsy findings available completion of cause of
Division of Vital	ding Ph h. After th funeral	Certification: To Be	27. Manne Death 1 Vatural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 1 1 28b. Time of Injury M	Other		one) dence 6 Other (Spe	city)
DIV	F e F	al Certifi	4 Homicide determined  29a. Certifier 1 Certifying Phys	28e. Place of Injury - At he building, etc. (Specifician: To the best of my known and the second second second second second second second second second second second second second second second second second second sec	y) wiedge death occurre	ed at the time, date and pla	City or To	cause(s) and manner as	stated
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	(Check only 2 Medical Examin	er: On the basis of examina and manner stated.	tion and/or investigation	on, in my opinion, death oc	curred at the time,	date and place, and due	to the cause(s)
) )	7		0. Name and a dress person who con	moleted cause of death //re-		35427		01-12	1
_	(2)		31. Date filed (Month, Day, Year)	NO TAN	coma Pr	rek MD	Jame	es C.Buxbau	m
	Sta Registr		JAN 1 6 2004	22. Registrar's Signa	liure die				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HAMPTON JAN. 12, 3:20 P M WASHINGTON 2004 BOYD /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months M 2 F Yrs. JULY 16, 1923 Director 578-09-8443 80 MARYLAND Usual Residence of Decedent the Maryland r 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 XYes 2 No MD. MONTGOMERY SILVER SPRING Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23s or the Medical Examiner must be BRIGGS CHANEY RD. 2100 20905 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after ☐Yes **2** No Yes, Give 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M FED. GOV'T. 12 G. S. A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LEONARD В. WASHINGTON MARGARET ANNA KNEESST 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALEXANDER/FRIEND BRIGGS CHANEY RD., SILVER SPRING, MD. 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of himportant: If ite any injury or of once. 1 ■ Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 1-16-2004 SUITLAND, MD. permit. 21. Signature of Funeral Service Dicenses CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 certificate 1 Yes 2 No 2 No or Attending Physician: ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Min patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours of To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 652381 who completed cause of death (Item 23a) (Type, Print) 2091 Adnestict Magastel 7000 Tarrill the Turong Park his State

DHMH 17 Rev 1/2001

Registrar

			1 - For Registrar	State of Marylar	,	artment of H			giene Reg. No.	004	03230
	Physici	an	1. Decedent's Name (First, Middle, La	1, War	d			2. Date of De Month	ath Day	Year 2004	3. Time of Death
6.	/Medi Examir		4a. Facility Name (If not institution, giv		<u> </u>	4b. City, Town, or	Location of De			unty of Death	Georges
*	Funeral Director		5. Social Security Number  220-142-14105  Usuel Residence of Decedent	Sex 7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 F Hours M	s. Date of Bin (Month, Da Feb. 20	y, Year) , 1915	9. Birthi Cou Pent	place (State or Foreign ntry) nsylvania
	e Maryland ta-f show	ctor	10a. State 10b. County Maryland Prince (		ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 X No
	with the a or 28	Dire	10e. Street and Number 10450 Lottsford F	Road		10f. Zip Code 20721			10g. Citizen	of What Cou	ntry?
036	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show solical Examinatoriusi be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 🕅 No If Yes, Give Year or Dates:	1			(Specify Yes or No erto Rican, etc.)	- 14.	Race - Ameri Black, White, ecity: Whi	etc.
21215-0036	e * - 38	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of v	working		of Business/In	dustry
	be filed stal Hygi of other	To Be Col	17. Father's Name (First, Middle, Last, Lloyd L. Moser	4	Glass	Historia	18. Mother's N	lame (First, Middle, Alice Ra	Maiden Sur	name)	
Maryland	ges 1 and 2 should be it of Health and Mental If Item 27 is marked or or other traumatic ev	ř	19a. Informant's Name/Relationship ( Rosalie Ward Cumm	•			and Number or	Rural Route Numbe	er, City or To		Code)
Baltimore,	Pages 1 and nent of Health int: If Item 27 iry or other ti		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Special	☐Removal from State	Place of Dispo cemetery, crea	osition (Name of matory or other place	ce)	Date	20c. Locati	on - City or To	own, State Virginia
Balti	permit. Page Department ( Important: If eny injury or once.		21. Signature of Funeral Service Licer		22	2. Name and Addres	ss of Facility	Gasch's F ve., Hyatt	uneral	Home,	P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	LYDE	er the mode of dyin  MBALA		iac or respiratory ai	rest,		Approximate Interval Between Onset and Death ONE WEEK
8760,	death certificate be executed e attending physicien and I for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c. NEPHROT Due to (or as a consec	quence of):	INDROM	E				ONE YEAR
P.O. Box 68	death certif e attending ed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	☐Ectopic pregnancy ☐ Other (specify)			23d.	Date of delive	ery Day Year
	ires sign 1 be		Part II. Other significant conditions of DEWENEATTIES				en in Part I.	23e. Did to	1		he cause of death?
Reco	Ф <del>-</del> В	Completed by	DELIENEMATIVE OSTED ARTHLIT DEEL VENOUS TO	*	rosis			24a. Was autop perfo	sy	4b. Were auto prior to co death? 1 \( \sum \text{Yes} \)	psy findings available mpletion of cause of
/ital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			To:		eath (Check only o			
of	Physi this c	. To	1 Yes 2 No	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatier		4 Januarsing	Home 5 Resid			y)
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.	Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	(Month, Day Year)	Injury ome, farm, str	M 1 🗆	k? Yes 2 □ No		Street and Nu		al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical Cer	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exer	hysicien: To the best of my kno miner: On the basis of examina and manner stated.	owledge, deat	h occurred at the tim vestigation, in my of	ne, date and pla pinion, death oc	ice, and due to the courred at the time,	cause(s) and date and place	manner as s	tated. the cause(s)
Bj	To the within 3	Med	29b. Signature and title of certifier	and marrier stated.		29c. License	e number		29d. Date sig	gned (Month,	Day, Year)
)	- > - 0		Claser			D40	0834		1-1	3-04	
			30. Name and address if person who MARY RUTH W 31. Date filed (Month, Day, Year)	completed cause of death (Iter	m 23a) (Type,	Print)	21	C. 20		Gra	NBGUT,
			MARY RUTH VO	) = 2 / N/ D 7.	JUS G	KARNINA	y CENT	TER DR.	H113	ma	290212
	Sta	ite	JAN 1 6 2004	Mary 152							

		For State Registrar		-	rtificate o	Health and f Death		Reg. No	),	W 101 0
Physicia	ın	Decedent's Name (First, Middle, Last)					2. Date of De Month	Da		3. Time of Death
/Medic		Silas Lawrence \( \) 4a. Facility Name (If not institution, give s			4b, City, Town	, or Location of De	Januar		4 2004 County of Dea	
Examin	er	48759 Chisleytown			St. Ini				t. Mary	
uneral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Day	If Under 24 H		th		thplace (State or Foreigountry)
rector		215-32-7027	IM 2□ F 6	8 Yrs.	MOTITIS Day	3 110013 1411	July 2	29 1	935 Mar	yland
M. I	-	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limit
February	Į.	Maryland St. Man	C+	Inigo	200					1 ☐ Yes 2 🔀 N
r 28a	Director	10e. Street and Number	.y 5   5t.	_ mrg(	10f. Zip Code	)		10g. Ci	tizen of What C	ountry?
23a o	a D	48759 Chisleytown	Road		20684			USA		
Item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic avant, I'm Medical Examinar must be motified at	/ Funeral	1 ☐ Never Married 2 ☐ Married	I2. Was Decedent Ever in U.t Armed Forces? 1 ☐ Yes 2 🙀 No If Yes, Give		Was Decedent of Yes, specify Co		(Specify Yes or No erto Rican, etc.)	)-	14. Race - Am Black, Whi	
ural',	d by	3 Widowed 4 Divorced	Year or Dates:					1 400 14	В	lack
than "nat is Medici	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. i		ne during most of w red)	rorking		ind of Business	
other than vant, Ita M	e Co	10th 17. Father's Name (First, Middle, Last)	1	Truc	ck Drive		ame (First, Middle			overnment
arked o	To B	Silas Warren Your	19			Helen	A. Chisle	2V		
is marked raumatic av	-	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Stre		Rural Route Numb		or Town, State,	Zip Code)
lem 27 is other tra		Marie R. Young / W	Vife	P.O.	Box 668	, St. In	igoes, Ma	ry1	and 206	84
if Item		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	20b. Pt	ace of Dispo	sition (Name of natory or other p	lace)	Date	20c. L	ocation - City or	Town, State
lant: I		`4 □Donation 5 □Other (Specify)			Jnited M	leth. 01	/17/2004	Sco	tland, 1	Maryland
Important: If Item 2 any injury or other once.	jan.	21. Signature of Funeral Service License	Mollia	22	2955 Hol	lywood R	oad, Leor	nard		ome, P.A. D 20650
		23a. Part1. Enter the cisease, or complications, or heart failure. List only on	cations that caused the death e cause on each line.	. Do not ent	er the mode of d	ying, such as cardi	iac or respiratory a	rrest,		Approximate Interval Between Onset and Death
physician and sthe burial-transit	edicai Examiner	resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	ence of):						18month
anding pr	n/Med	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnar		Tatania			T	23d. Date of de	livery
y the atte	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnar Other (specify)	icy			Month	Day Year
be d	۵	Part II. Other significant conditions con	tributing to death but not resu	iting in the ur	nderlying cause (	given in Part I.			_	o the cause of death? robably 4 DUnknow
has le 2	Completed						24a. Was autor perfo 1 Yes	rmed?	death?	utopsy findings availab completion of cause of 2 \sum No
E P	Be	25. Was case referred to medical examiner?					eath (Check only o	ne)		
this is	2	1 195 22110		R/Outpatien	3 DOA		Home 5 Resid			cify)
After	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	28b. Time of Injury		Yes 2 No	28d. Describe			
al Direction by	Certif	4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	me, tarm, str	эет, тастогу, опіс	ө	City or Tox			ural Route Number,
To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  Certifying Phys  2 Medical Examin	ician: To the best of my knowner: On the basis of examination and manner stated.	vledge, death ion and/or inv	occurred at the restigation, in my	time, date and plan opinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
ro ti	Σ	29b. Signature and title of certifier	_		1	nse number			e signed (Mont	
1	}	a Whole	7		1)	50686	)	1	1.5	~ 4
0		, 4,5000.							115 /	04

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Edna Louise Yingling 7:50 am Jan 14 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long View Nursing Home Manchester Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0ct 23. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 21 F Months Yrs. 213-10-7007D Director 87 1916 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 TYes 2 □ No Carroll Funeral Director Manchester 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3332 Main Street 21102 USA 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ➡No Specify: Completed by Specify 3 Hidowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home Department of Health and Mental Hygie Importent: If them 27 is marked other tenty injury or other traumatic event, treanments once. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles Herbert Bange Molly Augusta Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Grimes/sister 3215 Maiden Lane Manchester, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery 1/18/2004 Linwood, MD 21. Signature of Funeral Service Licensee 2Prints After Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner ettending physicien and for use as the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown \$ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? hes certificate 1 ☐ Yes 2-No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4⊌ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After **1** □Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A filled in by the f 2 Accident efter death 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral C completely filled. 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 3316 64 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) teven 21070 7 111 Maneret

**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year)

32. Registear's Signature

Genera It Spark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Month **Physician** BERNAL ISOLINA ,2004 January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 M 2 SE Months Schth America 215-66-0177 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland 10a. State Items 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at BALTIMORE 1 Yes 2 No MD Completed by Funeral Director EISTERSTOWN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 45A 21136 TAN TA COPRT 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 □ No HISPANIC 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired). 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KOMAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12909 GORESMILL Baltimore, 20b. Place of Disposition cometery, grematory 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04 4AMP 9 830 Envice 4 □ Donation 5 □ Other (Specify) 11824 Reisterstann RO 21. Signature of Funeral/Service Monsale INE Luneral Home Approximate Interval Between Onserand Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition ub dural Hemory day **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit The law requires that the death certificate be executed A DROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 3 Ectopic pregnancy
5 Other (specify) IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year ò 1 ☐ Yes 2 ☐ No detached Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate 1 🗆 Yes 25. Was case referred to medical examiner?

1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 28c. Injury at Work? in by the funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) PSECIEM 1300 5 Pending 1 Natural 1 ☐ Yes 2 ☑ No fell at home death. 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Numbers City or Town, State) 4 Homicide 306 Cantatta Ct #222

Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: completely filled in by the

> State Registrar

Medical

29a. Certifie

31. Date filed (Month, Day, Year) FEB 0 5 2004

29b. Signature and title of certifier

GENUU 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOME

**ORIGINAL** 

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

JATIGZOH JAKIZ

29c. License number

29d. Date/signed (Menth, Dey, Year)

DEPT SURGER

			1 - For Amend Item #2 Registrer AMEND ITEM #2	State of N 20b-c per 20c PER FH G		828 27 05/04 9					ental Hy	/giene	200	, 30 5 E O T
	Physici /Medio		Decedent's Name (First, Middle, La     Rosa Lee Burn								2. Date of D Month Januar	ry 28	,2004	3. Time of Death 9:50 P M
Ž	Examir		4a. Facility Name (If not institution, given St. Thomas Moore					Town, <i>o</i> r C <b>tsVi</b>	Location of	of Death			County of Deat rince G	_
	Funeral Director		5. Social Security Number 6. S 579-30-6821			last birthday) Yrs.	-	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D Sept.	ay, Year)	9. Birti Co 16 Sou	hplace (State or Foreign untry) th Carolina
	e-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  MD  Prince 0	eorge's		y, Town or Lo								10d. Inside City Limits ty⊡Yes 2 ☐ No
1	or 28	Director	10e. Street and Number			J	10f. Zip					10g. Citi	zen of What Co	untry?
<b>)36</b>	De liede within 72 nouts after death with the marylating tall Hygiene. Ad other then "naturel", or items 23a or 28e-f show event. It a Medical Examinar must be notified at	by Funeral	4922 La Salle F  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1  Yes 2 fif Yes, Give Year or Dates	s? ∄No					gin? (Spe i, Puerto I	ocify Yes or N Rican, etc.)		14. Race - Ame Black, White Specify: B1	rican Indian, e, etc.
1215-00	within 72 hounde.	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-40	r 5+)	life.	dent's Usu kind of wa DO NOT u	ork done a se retired,	furing most	t of workii	ng		nd of Business/	
nd 2	tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last Frank Eillerbs	)		l lic	JILE IT	akei			(First, Middle Eille:	e, Maiden		
s, Mary	int. Fages 1 and 2 should artment of Health and Men ortent: if item 27 is marke injury or other treumatic is.		19a. Informant's Name/Relationship Adelaide Smith		20h 5	3001	l Bla	denst	ourg !	Rd.,1		15, W		on, DC 20018
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ott 2008.		20a. Method of Disposition  1 Burial 2 Stremation 3 C  4 Donation 5 Other (Special Section 1)	fy)	NT A	Place of Disponentery, cres		c Cre	mato	2/ ry	18/04	Riv	cation - City or erdale	t win, State
Ba	Depa Impo any in		21. Signature Funeral Service Lice	Illea	no	3	3831 (	Georg	gia A	Lai ve.,l	WW, Was	shing	ral Hom	e. hc. 20011
760,	Wedical wascuted with the purial-transit	ical Examiner	23a. Part1. Enter the disease, or conshock, or heaft failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Conges Due to (or a b. Hyperi Due to (or a c. Cerebi Due to (or a	stive as a consect tensive as a consect rovasc as a consect	Heart quence of): ye Caro quence of, cular A	Fail	ure scula ent	ar Di					Approximate Interval Between Onset and Death
.O. Box 68	deam cermic e attending pl id for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 1€ months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 Feta	aldeath 3	⊒Ectopic p ⊒ Other <i>(s</i>					1	23d. Date of deli Month	very Day Year
ړ ۵	8 <u>5</u> 8	þ	Parli. Other significant conditions Degenerative			sulting in the u	ınderlying (	ause give	en in Part I.					the cause of death?
		Completed	Failure to Th	rive				-	_		24a. Wa auto per 1 □ Yes		24b. Were au prior to death? 1 \( \text{Yes}	topsy findings available completion of cause of 2 No
Vita	rnysicien: 1 this certificat ral director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 ☐ No	Hospital:	atient 2	] ER/Outpatie	nt 3□ D(	Othe			(Check only		3 □Other (Spec	cifu)
ion of	After		27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Ir (Month, I		28b. Time of Injury		28c. Injury Work	rat ⟨? Yes 2 □	2	28d. Describe			,
Division	I o the Hospitel of Attend within 24 hours after death To the Funerel Director: completely filled in by the f	Certification;	3 Suicide 6 Could not l 4 Homicide determined	289. Place of	Injury - At h etc. <i>(Speci</i>	ome, farm, st	reet, factor	y, office		í		(Street an own, State		ral Route Number,
:	e Hosp 24 hou e Fune etely fil	Medical		hysicien: To the be miner: On the basis and manner	of examina									
;	Vithin To th	Me	29b. Signature and title of certifier	lyrate	3.	mo		c. License 0051					e signed (Monti ruary 2,	
			30. Name and address of person who Esmerando Juan	1. /				and a	Ave	N.E	. Wash	ingto	on, D.C.	20018
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	- 4					<b>-</b>			<del>-</del>		

			For State Registrar	State of M		Departmen Certificati			Mental Hyg	jiene <sub>eg. No.</sub> 2 (	004	03235
6	Physici		Decedent's Name (First, Middle     Flavia Marie						2. Date of Dea Month Jan	Day	Year	3. Time of Death 1:00 P M
	/Medio Examin	200	4a. Facility Name (If not institution Howard County (	, give street and number)	ital		Town, or Imbia	Location of De		4c. County Howa	of Death	
	Funeral Director		5. Social Security Number 578-09-4806	6. Sex 7. Ag	e (In yrs. last biri	Yrs. If Under Months	1 Year Days	If Under 24 H Hours Mi		, Year)	Coun	lace (State or Foreign try) yland
	Maryland f ehow	jo	Usual Residence of Decedent  10a. State 10b. County  MD Howal	rd	10c. City, Town	or Location ott City					10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Direc	10e. Street and Number 5320 Dorsey Ha	all Dr., Apt	. 320	10f. Zip	Code 21042	2.	1	0g. Citizen of V	What Coun	try?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene limportants if item 27 is marked other than "natural, or Items 23s or 28s-f show any highry or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Marr 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.S.		lent of H cify Cuba		(Specify Yes or No- erto Rican, etc.)	Bla	e - Americ ck, White, c	etc.
21215-0036	ithin 72 hour he. han "natural healical E.	Completed b	15. Deceden (Specify only highest Elementary/Secondary (0-12)	's Education		Decedent's Usua (Give kind of wo life, DO NOT us	rk done d se retired	during most of w	rorking	16b. Kind of B		,
and 21	I be filed wintal Hygier ed other the	Be	8 17. Father's Name (First, Middle, Evaristo Graz:			Homemal	cer		ame (First, Middle, Line Zavric	Maiden Suman	Home ne)	
Maryland	d 2 should th and Men 7 is marke traumatic	2	19a. Informant's Name/Relations William Berton	nip (Type, Print)		-		and Number or	Rural Route Number	r, City or Town,	State, Zip	
Baltimore,	Pages 1 and nent of Health Int: If item 27 Iry or other to		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (S)	3 □Removal from State	20b. Place of cemeter	Disposition (Name of the control of	ne of ther plac	e)	Date	20c. Location -	City or To	wn, State
Balti	permit. Page Department of Important: If any injury or once.		21. Signature Service	~ Mo	1290	22. Name an Gary L 7250 Wa	d Addres Kai ashii	ss of Facility ufman Fi ngton B	neral Hon		adowr MD 2	idge MP, Inc 1075
1/60,	Physicien and but sicien be executed but street be executed but street but st	cal Examiner	23a. Part1. Enter the disease, or shock, ortheart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	ne.	lar, of): ypet/el.			ac or respiratory are			Approximate Interval Between Onset and Death
O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 \( \text{Yes} \) 2 (\( \text{IZ} \) No 9 \( \text{Unknown} \)	23c. If yes, outcome 1	2 Fetal death	3 □Ectopic pr 5 □ Other (sp		-			te of delive	ry Day Year
1	quires that I n signed by uld be deta	þ	Part II. Dther significant condition	ons contributing to death b	ut not resulting ir	the underlying c	ause give	en in Part I.		bacco use cont		e cause of death?  ably 4 []Unknown
Vital Records,	The law requirate has been spage 2 should	Completed							24a. Was a autops perform	med2	prior to con death?	osy findings available inpletion of cause of
ō	ding Physician: The In. After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Vatural 5 Pendin		ry 28b. 1	Time of 2	8c. injun Work	4 Nursing  at  (?	Home 5 Reside	ence 6 🗆 Oth		)
Division	or Atten fter deat jiractor: in by the	Certification:	2 Accident investig 3 Suicide 6 Could a 4 Homicide determ	not be 28e. Place of In	ury · At home, fa c. (Specify)	rm, street, factory		Yes 2 □No	28f. Location (Si City or Town		er or Rurai	Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	(Check only 2 Medical one)	g Physician: To the best Examiner: On the basis of and manner st	of my knowledge f examination an ated.	dor investigation	at the tim , in my of	ne, date and pla pinion, death oc	ce, and due to the c curred at the time, d	ause(s) and ma ate and place, 9d. Date signe	and due to	the cause(s)
	So Tawit	_	29b. Signature and title of certifie Robert	amenle	My N	1D 290	License L	252	curred at the time, d	Februar	Ly Z	2,2004
	2	1	20. Name and address of person Power Ammilia 31. Date filed (Month, Day, Year)	who completed cause of c	G N C	ollors Rol	250	ite 20	y Care	mjuille	212	ZJ-
	Sta Regist			5 2004	a desired to the second	Specie						

	1 - For State Registrar	State of Maryland / Dep Ce	ertificate of Death	Mental Hygiene Reg. No	2001	03236
Physician	Decedent's Name (First, Middle, L			2. Date of Death Month Da	Year 2004	3. Time of Death
/Medical Examiner	4a. Fecility Name (If not institution, gr	ve street and number)	4b. City, Town, or Location of Dea		. County of Death	
LXammer	Carroll Co.	General	Westminster		Carro	11
Funeral Director	215-30-8501	Sex 7. Age (In yrs. last birthda)	Months Days Hours Min	. (Month, Day, Year,	9. Birthp Coun	lace (State or Foreign try)
Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.  To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or I			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
recto	10e. Street and Number	oll Westm	101. Zip Code	10g. Ci	tizen of What Coun	try?
al Die	3409 Knot	tingham Rd	21157		45	A
Funeral Director	11. Marital Status		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	an Indian, etc.
à	3 ☐ Widowed 4 ☐ Divorced	1	1 ☐ Yes 2 ☐ No Specify:		Specify:	lack
Completed	15. Decedent's I (Specify only highest g	College (1-4or 5+) (Giv	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	orking 16b. k	(ind of Business/Ind	dustry
Son	11+h	Priv	late Nurse		tealth	Care
To Be	17. Father's Name (First, Middle, Las	io Nen	18. Mothers Na	me (First, Middle, Maider	ile ~	
	19a. Informant' Name/Relationship	(Type, Print) 19b. Mai	ling Address (Street and Number or R	ural Route Number, City		Code) 71157
	Aratha G Sm		9 Knotting ham			40
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Hemoval from State   }	ematory or other place)	200.2	ocation - City or To	
4	* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		22. Name and Address of Facility	7-04 B	HO. VV	harel Servi
once	> Rhod R			Randallston		
an	shock, or heart failure. List onl	mplication that caused the death. Do not end one cause on each line.				Approximate Interval Between Onset and Death
cal ner	disease or condition resulting in death)	Due to (or as a consequence of):			m	inutes
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):				
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence ol):				5.017
leted by Physician/Medical Examin		d				
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
by Ph	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
				1 ☐ Yes 2	□No 3□Prob	ably 4 Unknown
0.	<u> </u>			24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of 2 No
Be	25. Was case referred to medical examiner?	Hospital:	Other	ath (Check only one)		
1		1 ☐ Inpatient 2 ➤ ER/Outpatient 2 ≥ ER/Outpatient 28a. Date of Injury 28b. Time	ant 3 DOA 4 Nursing F	Home 5 ☐ Residence 28d. Describe how inju		)
Ition	1 Natural 5 Pending 2 Accident investigate	(Month, Day Year) Injury	Work?   M	,	,	
Certification:	3 Suicide 6 Could not 4 Homicide determine		treet, factory, office	28f. Location (Street ar City or Town, State		Route Number,
edical C		hysician: To the best of my knowledge, dea miner: On the basis of examination and/or i and manner stated.				
Medical Certification:	29b. Signature and title of partifier	Λ -	29c. License number	29d. Da	te signed (Month, L	Day, Year)
	> 1641:10	/ mn.	00061924	Febr	uary 2, 20	4004
	Howart P. Hendessa	o composition auso of death (Item 23a) (Type on 5-MD 2973 Manche	ster Rd Manchest	er MD 2	1102	
State	31. Date liled (Month, Day, Year)	32. Registrar's Sinature				

			1 - For State	State of Maryland / D	epartment of F	lealth and M	lental Hygi	ene 2004	03237
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  Aa. Facility Name (If not institution, give s  \$\frac{1}{2} \alpha \cdot \text{T}	Buffingti	~	r Location of Death	2. Date of Death Month 0 2		3. Time of Death
gar.	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year Months Days		8. Date of Birth (Month, Day, July 30,	Year) 9. Birth Con 1912 Mai	hplece (State or Foreign untry) Cyland
	e Maryland la-f ehow	ctor	10a. State 10b. County Maryland N/A	10c. City, Town Bal	or Location timore				10d. Inside City Limits  χ͡χ Yes 2 ☐ No
	n with th	ai Dire	10e. Street and Number 3835 Keswick Road		10f. Zip Code	21211	10	g. Citizen of What Co US	
020	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Any injury or other traumatic event, the Medical Examinar must be notified at angle.	by Funeral Directo	11. Marital Status  1 Never Married 3(3) Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Amed Forces? 1	13. Was Decedent of Hilf Yes, specify Cuba		ocify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
0-61717	within 72 ho pene. r then "natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12+	Completed) (College (1-4or 5+)	Decedent's Usual Occup Give kind of work done life. DO NOT use retired Nurse	during most of worki	ng	6b. Kind of Business/I Health Car	
yidin	should be filed and Mental Hyg marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Ignatius Myrtlin			18. Mother's Name Mary T	homas		
ž Ž	is 1 and 2 sh of Health and Item 27 ie m other traum		19a. Informant's Name/Relationship (Typ.  Lawrence Buffington 20a. Method of Disposition	Husband 38	Mailing Address (Street  35 Keswick Disposition (Name of crematory or other place)	Road BA	ltimore.	City or Town, State, Z  Maryland  Oc. Location - City or 1	21211
	permit. Pages Department of Important: If It any injury or o		X Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)  21. Signature of Puneral Service License	Marvia	nd Veteran ison Forest Burvee-H	s of Facility		Owings Mil	
ļ	Physician /Medical Examiner		23a. P.m. Enter the dise set or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a consequence of	Artery Fructive	1s Road  g, such as cardiac o  Disea  Ling	Baltimor respiratory arres		Approximate Interval Between Onset and Death V Cars
,0076	ate be executed hysicien and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of					2 122 (15
O. 100 O.	To the hospital or Attenuing Frigstoan: The law requires that the beant certificate be executed within 24 hours after fleath.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	,		23d. Date of delin Month	very Day Year
L (65)	quires mat an signed b uld be deta	by	Part II. Other significant conditions conditions		he underlying cause giv	en in Part I.		cco use contribute to	10
משב ו	siciant: The law requires the certificate has been signed rector, page 2 should be de	Completed	Sévere aor	tic stenosi	<u>S</u>		24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of 2 No
A 16	s certify	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Oth	er: 4 Nursing Hor		ce 6 □Other (Spec	ifv)
5 1	ing ruys i. After this uneral di	ion: T	27. Manner of Peath 1 Anatural 5 ☐ Pending	28a. Date of Injury 28b. Tir (Month, Day Yeer) Inj	ne of 28c. Injury	y at 2 k?	8d. Describe how		
SI SI SI SI SI SI SI SI SI SI SI SI SI S	to the mospital or attending mystotain; the within 24 hours store death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)		Yes 2 □No	8f. Location (Stre City or Town.	et and Number or Rui State)	al Route Number,
:	vithin 24 hours after or within 24 hours after To the Funeral Dir completely filled in	edicai (		cien: To the best of my knowledge, er: On the basis of examination and/ and manner stated.					
i	within to the comp	Me	29b. Signature and title of certifier	2 MD	29c. Licens	1 3 9 1	-	Date signed (Month,	Dey, Year)
4	10		30. Name and address of person who cor	A1 /	nue, Ba	utimore	Mar	yland a	21227
	Sta	ite	31. Date filed [Morth, Day: Year)	32. neglarans Signature	1				

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar	State of Marylar	-		of Health a of Death	and Mental	Reg. No	2001	. 03238
Physic		1. Decedent's Name (First, Middle, La: Edward C.	Baxter, Jr.	•			Month	n Da	3 200d	All Agent
/Med Exami		4a. Facility Name (If not institution, giv	SEL HOSPI		GUE	, , ,	715	A		th  Acuri DEC  thplace (State or Foreign
Funera Director		217-18-5263		80 Yrs.		ays Hours	Min. July 2	of Birth Day, Year 1923	) "Co	Maryland
Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD n/a	10c. C	ity. Town or Lo						10d. Inside City Limits 1 □ Yes 2 □ No
with the a or 284	Direc	10e. Street and Number 3719 Tenth Street			10f. Zip Co	21225		10g. C	itizen of What Co	ountry?
Baitimore, Maryland 21213-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 No WW If Yes, Give Year or Dates:	11	Was Deceden If Yes, specify	t of Hispanic Ori Cuban, Mexican	gin? (Specify Yes , Puerto Rican, etc	or No-	14. Race - Ame Black, Whit Specify: Whi	e, etc.
Vithin 72 houndle	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)  n/a	(Give	dent's Usual C kind of work of DO NOT use i	done during mos retired)	t of working		Kind of Business	Andustry
Maryland 21215-0036 nd 2 should be filed within 72 hours aft lith and Mental Hygiene. 27 is marked other than "natural, or r treumatic event, tha Medical Exam	To Be Co	17. Father's Name (First, Middle, Last, Edward C. B.		10010			or's Name <i>(First, M</i>		n Surname)	
Mary d 2 sho th and h		19a. Informant's Name/Relationship ( Thomas E. Baxter-son	Type, Print)			Butler,	or or Rural Route A MD 21023	lumber, City	or Town, State, .	Zip Code)
Ges 1 and tof Heal		20a. Method of Disposition  1	20b.	Place of Dispo	osition (Name matory or othe	of or place)	Date 2/10/04		ocation - City or	
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any injury or othe		*4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lices			2. Name and A	Gardens  Address of Facility  Arford Rd		J. Ruck	, Inc. Fu	neral Home
Physiciar /Medica	1	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as e conse	quence ol):		56		ory arrest,		Approximate Interval Between Onset and Death
68760, inficate be executed by g physician and as the burial-transit of	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	quence ol):						
Geath cert death cert e attendin ed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Dive birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3	⊒Ectopic preg ⊒ Other (spec				23d. Date of de Month	livery Day Year
rdS, P. quires that n signed b	b	Part II. Other significant conditions	contributing to death bul nol re	sulling in the c	underlying caus	se given in Part I	. 23e.	Did tobacco		o the cause of death?
Vital Records, P.O sicien: The law requires that the certificate has been signed by the rector, page 2 should be detached.	Completed							Was an autopsy performed?	prior to death?	ulopsy lindings available completion of cause of
	o Be	25. Was case relerred to medical examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatie	int 3 DOA	Othor	of Death (Check		6 ∏Other (Soe	ncify)
ding After	-	27. Manner of Death  1 Majural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of		Injury at Work?	28d. Des	cribe how inju		Oly
in the second	Certification:	3 Suicide 6 Could not to determined	building, etc. (Spec	eify)			City	or Town, Stai	te)	ural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	Medicai		hysicien: To the best of my kr miner: On the basis of examir and manner stated.							
To the within To the comple	Me	29b. Signature and title of certifier	D	MS	29c. L	icense number	9	29d. D.	ate signed (Moni	th, Day, Year)
10+1		30. Name and address of person who	completed cause of death (It	1	Print)	glen	burne	Mi	> 200	061
Regis	tate strar	31. Date liled (Month, Day, Year)	32. Registrar's Sig	ture	(	houts ;				

DHMH 17 Rev 1/2001

Columnal Booker

		•	For State Registrar	State of Maryla		artmen rtificate			and M		giene Reg. No.	200		03239
*	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last)     Mary Virgini     Aa. Fecility Neme (If not institution, give s	street and number)				Location o	of Death	2. Date of Dea Month Februa	Day 1ry 4 4c. (	County of D	ar 4 eath	3. Time of Death  2:30 A <sup>M</sup>
	Funeral Director		217-22-2074		s. last birthday) Yrs.	Esse If Under Months		If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da NOV 18		altim 9.0 25 W	Birthpla	ce (State or Foreign V) Virginia
0036	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural; or liems 23e or 28e-1 show downt, the Marilesi Evaluation man be notified at	d by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	ES  12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		10f. Zip 21 Was Deced If Yes, spec	221 dent of His cify Cubar 2 X No	Specify:	gin? (Spe n, Puerto	ocify Yes or No Rican, etc.)	USA - 1	4. Race - A Black, W Specify:	Countr mericar /hite, et	n Indian, c. White
Maryland 21215-0036		To Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) UK.  17. Father's Name (First, Middle, Last) George W. Bickers  19a. Informant's Name/Relationship (Ty	college (1-4or 5+)	Secr	dent's Usua kind of wo DO NOT us etary	rk done d se retired,	18. Mothe	er's Name	ng o (First, Middle, cilia T ol Route Numbe	Inve Maiden Tynan	stmen Sumame)	t F	irm
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marks any injury or other traumatic <u>once.</u>		Phyllis J. Erlich,  20a. Method of Disposition  1  Burial 2 MCremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Federal Service Licens	temoval from State	Place of Dispo cemetery, cre Metro C	osition (Nar matory or o remat	ne of other place OLY	inc.	2-4	-04	20c. Loc Bal	owson cation - City .timor	or Tow	m, State
760,	Physician /Medical Examiner e partial and	dical Examiner	Faward A C  23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that inhitated events resulting in death) Last	respectik cat sthat caused the de	ath. Do not en	299 F	rede:	rick g, such as	Road	of MD, Balt or respiratory a	imor	e, MD	1	Approximate niterval Between Onset and Death
.O. Box 68	that the death certificate ed by the attending phy detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tat death 3	⊒Ectopic p ⊒ Other (sp					2	23d. Date of Month		y Day Year
ords, P	w requires that been signed b should be deta	ted by Pl	Part II. Other significant conditions co		esulting in the o	underlying o	cause give	en in Part I		1 🗆 '	Yes 2[	]No 3□	] Proba	cause of death?
ital Rec	ien: The law artificate has b ctor, page 2 sl	Be Completed	Hypotyroid's m Carcinoma - l 25. Was case referred to medical examiner?	neast						24a. Was autoj perfo 1  Yes	psy ormed? 2 ☑ No one)	prior deati 1 🗆 `	to com h? Yes 2	sy findings available pletion of cause of
Division of Vital Records, P.O.	To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Certification: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	lospital: 1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At building, etc. (Spe	28b. Time of Injury	of S	28c. Injun Work 1 🗀	/ at	No	me 5 Resi 28d. Describe 28f. Location ( City or To	how injury	y occurred d Number o		Route Number,
~	To the Hospitel within 24 hours to To the Funerel Completely filled	Medical Ce	(Check only 2 Medical Examone)  29b. Signature and title of certifie	sician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, dea	nvestigation 29	c. License	ne, date ar pinion, dea	ath occur	and due to the red at the time,	date and	and manne place, and e signed (M	due to t	ay, Year)
7	5		30. Name and address of person who complete the Michael Schw	ompleted cause of death (I		, Print)				ay, Su				en Burnie,
	St Regist	ate	31. Date filed (Month, Day, Year) FEB 0 5 200	32. Registrar's Sig		eder.								

State of Maryland / Department of Health and Mental Hygiene State
State
Registrar AMEND ITEM #3 PER PHY G828 2/05/04 Stertificate of Death Reg. No. 🤈 2. Date of DeathFEB 03,2004 1. Decedent's Neme (First, Middle, Last) **Physician** BEAUDIN 1525 M ANNA /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A TOHNS HOPKINS B.ALTIMORE BAYVIEW MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR 26, 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Virginia **Funeral** Days Months Hours Min. 1 M 2 XF 1926 Director 213-20-7311 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be nutified at Maryland Baltimore Middle River 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 Stabilizer Drive 21220 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Mamed 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Businesswoman Self Employed 9 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 Is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Pruden Cora Emory ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Jakum/Daughter 2212 Park Drive Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 2-4-04 Baltimore, MD 21. Signature of P <sup>22</sup> Name and Address of Facility Cremation Society of MD. 299 Frederick Road Bal puce Thomas Gregor

Cremation Society of MD. In 299 Frederick Road Baltim

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inc. Baltimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. physician Completed by Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No P.O. he detached 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 🗆 No 3 M Probably 4 □Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₹ No 1 | Inpatient ě ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation 1- Natural М 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Funaral C filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical etely and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21007 MEDICAL DOCTOR FEBRUARY 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL LENTER 4940 EASTERN AV WILLIAMHUNG BALTIMORE MD 21724 JOHNS HOPKINS BAYVIEW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 05 2004 Registrar FEB September 1

			For State Registrar	State of M	Maryland	d / Depa <i>Cer</i>	artment of H	lealth and D <i>eath</i>	d Mental Hyg	giene 20	04 (	03241
			1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	Day '	Gear 3.	Time of Death
	Physicia /Medic		Ellen LaRue	Baker					Februar			:00 a. ™
è	Examin		4a. Facility Name (If not institution		er)		4b. City, Town, or	Location of De	eath	4c. County of		
			3 Southerly C		Ama //m sem //	and historia val	Towso		Irs. 8. Date of Birth		imore	(State or Foreign
	Funeral Director		5. Social Security Number 220–50–0872	1 M 2 X F	Age (In yrs. la 79	Yrs.	Months Days		lin. Jan. 27	1925	Maryla	
			Usuel Residence of Decedent					1	0011: 27	, 1525	ridi yil	1110
	yland		10a. State 10b. County	-	10c. City	, Town or Lo	cation					nside City Limits
	a-fei	cto	Md. Balti	more		Towso	n				1	Yes 2X No
	or 28	Sire	10e. Street and Number				10f. Zip Code		1	l 0g. Citizen of Wh		
	ath w	Funeral Director	3 Southerly					286		144 Day	USA	dia
	er de	nue	11. Marital Status  1 Never Married 2 Married	12. Was Decede Armed Force	s?	S.   13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? in, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	Black	- American In White, etc.	dian,
36	rs aft	by F	3 Widowed 4 □ Divorced	If Yes Give			Yes 2 No	Specify:		Specify:	Whi	Lte
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ta Musical Exerciter mast be notified at	pe	15. Decedent				lent's Usual Occupa			16b. Kind of Bus	iness/Industry	y
215	hin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. I	kind of work done of OO NOT use retired	)) i)	working			
2	d wit	Ö		+4		Re	gistered			Nursi		
Maryland	be filed tal Hygie d other	Be	17. Father's Name (First, Middle,						Name (First, Middle,			
<u>yla</u>	should be i and Mental i marked o	၉	Charles Calvi						h Catherin			
Nar	(4		19a. Informant's Name/Relations						Rural Route Number			a)
e,	1 and Health am 27 thar tr		Mr. Michael Bak 20a, Method of Disposition	er/ Son	20b. PI	ace of Dispo	sition (Name of			Md. 2128		State
5	Pages nent of I ant: # Itu	3	1 Burial 2 ☐ Cremation		ite i		natory`or other plac Cemetery		7-04	Moodsbo		
Baltimore,	artme ortani injury	. 16	*4 □ Donation 5 □ Other (S)  21. Signature of Fyner® Services		116.		. Name and Addres		7-04		50 York	
Ba	permit. Departr Importa any inju		N X	4				•	ral Home,			
14	0.5 A.F.		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death						App	proximate erval Between
	Proysician		Immediate Cause (Final	only one cause on each	72	1/	4				Ons	set and Death
	/Medical		disease or condition resulting in death)	a. Due to (or	as insequ	iene of):	/				751	7 EG/
	Examiner		Commission line and disease	b								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dicease or injury)		as a consequ	ience of):						
/	ecute and trans	Examiner	Causa (Disease or injury that initiated events resulting in death) Last	c								
8760,	ate be executed hysician and the burial-transit		resulting in dealing Last	Due to (or	as a consequ	ience ot):						
		Physician/Medical		d								
9 X	death certific e attending pl ed for use as f	/Me	IF FEMALE:	23c. If yes, outcor	me of pregnai	ncy				23d. Date	of delivery	
Вох	atter I for u	ciar	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal t at time of de		Ectopic pregnancy Other (specify)			Mont		Year
o.	0 0	ysi	1 □ Yes 2.8 No 9 □ Unknown	9□ Unknow	n							
<b>D</b>	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant condition	ons contributing to deat	h but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to the car	use of death?
Records,	w require: been sig should b								_ 1 🗆 Y	es 2□No 3	Probably	4 Unknown
000	aw requise been 2 should	Completed							24a. Was a	an 24b. W	ere autopsy fi	indings available
Ä		mo							perform	med? de	ath? Yes 2/2	
Vital	ysician: The is certificate his director, page	Bec	25. Was case referred to medical examiner?					26. Place of	Death (Check only or			
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 No	Hospital: 1 🗆 Inp.	atient 2 🗆 I	ER/Outpatier		4 U IAMISIN	g Home 5 Resid	ence 6 🗆 Other	(Specify)	
u c		on:	27. Manner of Death 1 ✓ Natural 5 ☐ Pendin	28a. Date of I (Month,	Injury Day Year)	28b. Time of Injury	Worl		28d. Tescribe h	ow injury occurred	1	
sio	Attending r death. ector: Afte by the fune	cati	2 Accident investig	not be				Yes 2 □ No	100/1			At Al sales
Division	or At offer of Direct in by	Certification:	4 Homicide determ	ined 28e. Place of building	etc (Special	me, farm, str	eet, factory, office		City or Town	treet and Number n, State)	or Hurai Hol	ite Number,
_	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the		29a. Certifier Certifyin	ng Physiqian: To/the by	st of my know	wledge, death	occurred at the time	ne, date and pl	ace, and due to the c	ause(s) and man	ner as stated.	
	1 24 h	edical	(Check only 2 Medical one)	Examiner: On the basi and manyer	of examinat	ion and/or in	vestigation, in my o	pinion, death o	ccurred at the time, d	late and place, an	d due to the	cause(s)
	To the To the comple	ž	29b. Signature and title of certifie			/	29c. License	e number	/ 2	29d. Date signed	Month, Day,	Year)
	, /		• (//	15-1			104.	273	6	2-3	-0C	-
	K.Y		30. Name and address of person	who complete voluse	of death (Nem	23a) (Type,	Print)	1 (0)	16	11/	7 ,	200
	1		31. Date filed (Mohth, Day, Yeer)	22 82	istrar's gna	1) We		101	VSD.	101	416	UK
is,	Sta Registi		CI	R 0 5 200	Page	يار مناه	Frenk					

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

DHMH 17 Rev 1/2001

**ORIGINAL** 

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	•	epartment of Health and In		eg. No. 200	4 03243
	Physicia	an	1. Decedent's Name (First, Middle, Last) ERNEST	BRAVI	MANN	2. Date of Deat F ENBonth	<sup>h</sup> 2 <sup>Day</sup> 20 <b>94</b>	3. Time of Death 8:50 P
100 000	/Medic Examin		4a. Fecility Name (If not institution, give si 3402 W. STRATHMORE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Dea	uth
	Funeral Director		210-10-3345	7. Age (In yrs. last birtho	Months Davs Hours Min.	8. Date of Birth Month, Day, JUNE 5,	1924 GER	nthplace (State or Foreign OUNTY) MANY
	Maryland -f show lied at		Usual Residence of Decedent  10a. State 10b. County N/A	10c. City, Town of BALTIMOR	or Location RE			10d. Inside City Limits 1   Yes 2   No
	h with the 13a or 28a at be noti	ai Direc	10e. Street and Number 3402 W. STRATHMORE	E AVE	10f. Zip Code 21215	1	0g. Citizen of What C	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show appringury or other treumatic event, I'm Madical Examinar must be retiffied at ODGe.	by Funeral Director	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □YYes 2 □ No WWII If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto     □ Yes 2 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	within 72 ho lene. then "natur ne Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) ((	Decedent's Usuat Occupation Give kind of work done during most of work ife. DO NOT use retired) UFACTURER	king	16b. Kind of Busines	s/Industry
and 2	should be fited nd Mental Hygi i marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) SIGMUND	BRAVMANN	18. Mother's Nam BERTHA		Maiden Sumame) FROEHLICH	
Maryland	id 2 shou Ith and M 27 Is mar treumat		19a. Informant's Name/Relationship (Tyr MRS. MARGARET BRAVI		Mailing Address (Street and Number or Ru  2 W. STRATHMORE AVE			
Baltimore,	Pages 1 and nent of Health nt: If item 27 iry or other tr		20a. Method of Disposition  1 Kaurial 2 Cremation 3 Re  4 Donation 5 Other (Specify)	20b. Place of D	Disposition (Name of APIAVAS OF CHESED 2/3/	Date	20c. Location - City of ANDALLSTON	
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service License		22. Name and Address of Facility SO 8900 REISTERSTOWN R	L LEVINS OAD PIKE	ON & BROS SVILLE, M	INC. 0.21208
	Physician	X ()	Immediate Cause (Final disease or condition	cations that caused the death. Do not e cause on each line.	of enter the mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
× 109289	Medical Examiner b physician and streep burial-transit	edical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (ir as a consequence of  Due to (or as a consequence of  Due to (or as a consequence of	ertery disease			
.O. Box 68	ath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome of pregnancy 1	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of d Month	elivery Da <sub>y</sub> Year
Ω.	uires that the de signed by the a id be detached t	by	Part II. Other significant conditions con	ntributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did to		to the cause of death?  Probably 4 Unknown
Division of Vital Records,		Completed				24a. Was a autops perform	sy prior to	
Vita	Physician: This certificated director, p	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outp	100	th (Check only or	ne) ence 6 ⊡Other (Sp	ecify)
lon of			27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Tir			ow injury occurred	
Divis	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farr building, etc. (Specify)	m, street, factory, office	28f. Location (S City or Tow	treet and Number or i n, State)	Rural Route Number,
	To the Hospitel or At within 24 hours after C To the Funerel Direct completely filled in by	Medical			death occurred at the time, date and place /or investigation, in my opinion, death occu			
	To the within 2 To the complet	M	29b. Signature and title of certifier	18 10)	29c. License number	2	29d. Date signed (Mo	nth, Day, Year)
•	BX		30. Name and address of person who co	1	051426		ren 51	0001
	Ct.	ate	Elliot Roths	32. Registrar's Signature	Id court Rd, Pik	esculle	MD	
1	Regist		FEB 0	5 2004 Depart	10 sparker			

			For State Registrar	State of Ma	ryland	-	rtmen tificate				ı	Reg. No.	211	) 4	032	244
j	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last     A. Facility Name (If not institution, give     19 West Midland I	Helen	C	• ]	Balk 4b. City,		Location o		2. Date of Dea Month January	y 38		ar 4 4 Death timor		• м
	Funeral Director		5. Social Security Number 6. Se 213-16-9079 Usual Residence of Decedent	x 7. Age ∃M 2√3√F 8	(In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) Oct. 1	v. Year)	9. 17 M	Birthplace Country) aryla	(State or .nd	Foreign
:	se Maryland Ba-f ehow	Director	10a. State 10b. County  Maryland Ba.	ltimore	10c. City, 1	fown or Loc	,			Mic	ddle Ri				nside City	
:	ath with the 23e or 21		10e. Street and Number 19 West Midland	Road  12. Was Decedent E	vos in H S	12 1	10f. Zip	2	1220	ain? (Sae		Uni	ted S	tates		
036	ours after de rel', or item	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No lf Yes, Give Year or Dates:		i	Yes, spec		Specify:		cify Yes or No- Rican, etc.)			Vhite, etc.	ite	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene, is marked other than "naturel; or Itema 23e or 28e-f ehow aumatic event, the Marilcal Exame at must be collified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5-		16a. Deced (Give life. L	lent's Usua kind of wor DO NOT us Cler	k done d e retired)	uring mos	t of workii	ng		ind of Busin Retail		•	
פ	should be filed nd Mental Hygis marked other umatic event, II	To Be Co	11 Years 17. Father's Name (First, Middle, Last) William F. Coler	man							(First, Middle, ed Wilk					
	1 and 2 sho Health and I tem 27 is me		19a. Informant's Name/Relationship (7 Elaine Holbrook) 20a. Method of Disposition		20b. Plac	20 W	est N	idla	and R	oad	/Route Numbe Middle	Riv	r Town, Star rer, M	aryla	ind	2122
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: if Item 27 is marke eny injury or other traumatic <u>once.</u>		1X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licenses	)		etery, cren Air 22	Mem.	Gdns	s of Facili	h	O4 Home of		el Ai		ryla	nd
	19/31		23a. Part1 Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final	lications that caused the cause on each line.	9.	Do not ente	922 W	ise e of dying	Ave. g, such as	Dur cardiac o	ndalk, I	Mary	land	2122 Apr	2 proximate erval Betw set and De	een
760,	that the death certificate be executed  Wedpin and the attending physicien and detached for use as the burial-transit	Ilcal Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	NASS consequer	nce of):				<b>9</b>						
.O. Box 68	The law requires that the death certifica are has been signed by the attending phagge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal de	eath 3	Ectopic pr						23d. Date of Month	delivery Day	γ Υ	ear
rds, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions of	ontributing to death bu	t not resulti	ng in the ur	nderlying c	ause give	in in Part I	•			use contribut			
Vital Records,	: The law requ cate has been page 2 shoul	Completed											prior		tion of ca	vailable use of
ō	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	tlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatier 28a. Date of Injun (Month, Day		NOutpatien 8b. Time of Injury		8c. Injury Work	at	ursing Hor	n (Check only one 5 Residence 1986). Describe h	dence		Specify)		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At hom . (Specify)	e, farm, str	eet, factory	, office		2	28f. Location (S City or Tov			r Rural Ro	ute Numb	967,
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of iner: On the basis of and manner sta	of my knowle examination ted.	edge, death n and/or inv			ne, date ar pinion, dea	nd place, a ath occurre			and manne d place, and te signed (N			
	2 3 2 8		30. Name and address of person, tho	completed cause of de	eath (Item 2	3a) (Type.	Print)	1) 3	2013	3	o BA	Z	/21	200	4	
	Sta Regist		31. Date filed (Month, Day, Year)	327 Registra	N	10	107	BEA	con	) K	1 /34	40	MO	21		)

	1	For State Registrar  1. Decedent's Name (First, Middle, Lat			artment of H			eg. No.	2004	03245
icia	n	RUTH STROEBEL					February		2004 Year	1:00P M
dic:		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	<u> </u>	_	County of Death	
		205 East Joppa	Road		Tows				Baltin	
al or	4		ex 7. Age (In yrs. I.	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day AUGUST 23	Year) , 191	9. Birth Cou 1 Mary	place (State or Foreign intry) Land
	<b>—</b>	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	į	Maryland Baltimore	Tows	son						1 ☐ Yes 2 ☐ No
once.	Funeral Director	10e. Street and Number 205 East Joppa Road			10f. Zip Code 21286		1	_	en of What Cou ISA	intry?
	nera	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	spanic Origin? (Spendar)	ecify Yes or No-	1	4. Race - Ameri Black, White	
	þ	1 Never Married 2 Married	Amed Forces?, 1		1 □ Yes 2/0X No	Specify:				nite
	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation Juring most of work	ing	16b. Kin	d of Business/Ir	ndustry
Ì	ğμ	Elementary/Secondary (0-12)	College (1-4or 5+)		ninistrator	)		Can	Company	
	ပ္	17. Father's Name (First, Middle, Last,	4	Aut	iiiiisti dusi	18. Mother's Name	e (First, Middle,			
Ì	To Be	George Henry August S	itroebel			Mary Eli	zabeth Br	OWN		
1	-	19a. Informant's Name/Relationship (	**	1	ng Address (Street			-		p Code)
1		Eleonore R Schleupner			Orchard Poir		idena Mary Date		ZTTZZ ation - City or T	own State
		20a. Method of Disposition 1 XX urial 2 □ Cremation 3 □	Hemovai from State		osition (Name of matory or other place	θ)				
		'4 □Donation 5 □ Other (Specifical Signature of Funeral Service Lices			ley Mem Gar 2. Name and Addres				ville, Ma	
		21/Signature of Funeral Service Licen	100 h	2	2. Name and Addies	6500 York				
	1	23a. Part1. Enter the dise ase, or on shock, or heart failure. List only	plications that caused the death	n. Do not en	ter the mode of dyin				, raiyidi	Approximate Interval Between
ı		Immediate Cause (Final	one cause on each line.	4	Pearl Fa	م داد			Į.	Onset and Death
İ		disease or condition resulting in death)	a. Due to (or as a consequence		leart ta	ilume				mmmy
ı		On any stirilly list and disings	h							
4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C							
	cal Ex	Tosulting in Coath, East	Due to (or as a consequent	dence or).						
	Medi	IF FEMALE:								
	an/h	23b. Was decedent pregnant	23c. If yes, outcome of pregna	death 3	⊒Ectopic pregnancy			2	3d. Date of deliv Month	very Day Year
	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	4□Pregnant at time of do 9□ Unknown	eath 51	Other (specify)	·				
	Ph	Part II. Other significant conditions	contributing to death but not rest	ulting in the u	underlying cause giv	en in Part I.	23e. Did to	bacco us	se contribute to	the cause of death?
	d by						1 □ Y	es 20	No 3□Pro	bably 4 Unknown
1	Completed						24a. Was a		24b. Were aut	opsy findings available impletion of cause of
	mo						autop: perfor	med? 2 <b>X</b> No	death?	2 No
	0	25. Was case referred to medical				26. Place of Deat				
1	To B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 X Resid	ence 6	Other (Speci	ify)
ı		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	<b>c</b> ?	28d. Describe h	ow injury	occurred	
	cati	Accident investigation				Yes 2 □ No	OOL Leasting /C	*****	l Number of Ru	ral Route Number,
	Certification:	4 Homicide determined			reet, factory, office		City or Tow	n, State)	Number or Hui	ar Houle Number,
	Medical Co	29a. Certifier (Check only one)  1 Certifying P. 2 Medical Exa	nysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred at the tirnvestigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time, c	ause(s) a	and manner as place, and due	stated. to the cause(s)
ì	Me	29b. Signature and title of certifier			29c. Licens				signed (Month	
		Mary			Print) Pork Ro	1704		34	FEB 2	2004
		V- V		22a) /Tuno	D-i-t)		·			
)		30. Name and address of person who	completed cause of death (Item	1 23a) (1ype	, Print)		1			

			For State of M State Registrar Amend Item#18perFHG828 2/		partment of Health a		2004	03246
			Decedent's Name (First, Middle, Last)	22,01 211 0	orimodic or Bodin	2. Date of Death	h Day Yeer	3. Time of Death
	Physicia /Medic	al	Pearl Co	oper		Februa	aru 3,2004	20:35
	Examin	er	4a. Fecility Name (If not institution, give street and number,	Pinl	4b. City, Town, or Location	of Death	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex / 7. Ag	ge (In yrs. last birthda	ay) If Under 1 Year   If Under Months   Days   Hours	24 Hrs. 8. Date of Birth Min. (Month, Day,	9. Birthi	place (Stete or Foreign
	Director		216-36-5855 1□M 2፟፟MF	64 Yrs	Months Days Hours	JUNE 18		RYLAND
	tand ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	a-f sh	ctor	MARYLAND BALTIMORE	CHA	SE			1 Yes 2 No
	vith the	Director	10e. Street and Number		10f. Zip Code	10	0g. Citizen of What Cou	ntry?
	ns 23e	erai	12 3 0 6 EASTERN AVENUE  11. Marital Status 12. Was Decedent	Ever in U.S. 1	21220  3. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical	igin? (Specify Yes or No-	U.S.A. 14. Race - Ameri	can Indian,
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once.	Completed by Funeral	1X Never Married 2 Married 1 Yes 2X If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexical  1 Yes 2XXNo Specify:		Black, White, Specify: BI	etc. ACK
5-003	72 houndard	eted	15. Decedent's Education (Specify only highest grade completed)	(G	cedent's Usual Occupation ive kind of work done during mos	st of working	16b. Kind of Business/In	dustry
2121	within ane. than	mpi	Elementary/Secondary (0-12) College (1-4or	5+)	a. DO NOT use retired)		HEALMH CAD	T.
	filed Hygie other	Be Co	10th grade  17. Father's Name (First, Middle, Last)	NOF	SING 18. Moth	er's Name (First, Middle, M	HEALTH CAR	<u> </u>
/lan	uld be Mental irked itic ev	To B	CARROLL BENJAMIN REED		-GLe	ORIA COOPER I	illian Cooper	CREEN
Maryland	2 sho and I Is me		19a. Informant's Name/Relationship (Type, Print)	19b. M.	ailing Address (Street and Numb	er or Rural Route Number,	City or Town, State, Zip	) Code)
	1 and Health em 27		Frank Reed/Brother  20a. Method of Disposition	20b. Place of Di	29 Eastern Ave		d., 21220 20c. Location - City or To	own, State
Baltimore,	Pages nent of I int: If It		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	'	irematory or other place)	02-07-04	MIDDLE DIVE	R. MARYLAND
a E	permit. I Departm Importal any inju		21. Signature V uneral Service Licensee	1 101111	22. Name and Address of Facili WM C BROWN COM	ty		
<b></b>	89E # 9		charles of voi	vell	321 S PHILADELI	PHIA BLVD, A	BERDEEN, MD	21001
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final	d the death. Do not ine.	enter the mode of dying, such as	cardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a consequence of);	rrhythm	110	^	minutes
	Examiner		Sequentially list conditions, b. hype	rcarl	DIC respi	ratoryt	ailure	1110/11/15
	be sit	liner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):	lastructive	o Dulana	acia, de	years
	akecut n and al-tran	Examiner	that initiated events c.	a consequence of):	DSTUCTIV	e parrior	rai y ais	ase.
58760,	icate be executed physician and s the buriat-transit	dical	d					
_			IF FEMALE:	of arrange				
Вох	lhat the death certific ed by the attending p detached for use as	Physician/M	in the past 12 months?	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver	ery Day Year
Ö.	t the d by the rached	hysi	1 Yes 2 No 9 Unknown					
rds, P	8 E 6	þ	Part II. Other significant conditions contributing to death	out not resulting in th	e underlying cause given in Part		eacco use contribute to t es 2 □ No 3 □ Prot	\ /
Records,	e law requir has been si je 2 should	Completed				24a. Was ar	24b. Were auto	opsy findings available impletion of cause of
		Con				perform 1 ☐ Yes 2	ned?   death?	2 No
Vital	Physician: Th rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpat	ent 2 ER/Outpa	Other	e of Death (Check only one ursing Home 5 Reside		6.1
of	g Phy erthis eral d	<b>-</b>	27. Manper of Death 28a. Date of Inj	ury 28b. Tim	e of 28c. Injury at	28d. Describe ho		у/
sior	Attending or death. ector: Afte by the fune	atio	2 Accident investigation		M 1 Yes 2	No		
Division	s atter d	Certification:	determined 200. Flace of it	jury - At home, farm, tc. <i>(Specify)</i>	street, factory, office	28f. Location (Sti City or Town	reet and Number or Ruri , State)	al Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely tilled in by the funeral director,	edical (	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examination and/o	eath occurred at the time, date ar r investigation, in my opinion, dea	nd place, and due to the ca ath occurred at the time, da	use(s) and manner as s are and place, and due t	tated. o the cause(s)
L.	To the To the Comp	×	29b. Signature and title of certifier		29c. License number	29	9d. Date signed (Month,	Dey, Year)
,	$\sim$		ranna Patel M	)	2301	1 Fe	ebruary 3	3,2004
	19		30. Name and address of person who completed cause of	death (Item 23a) (Ty	medical	Center	Rollin	ove, mo
	Sta			rar's Signature	1			
	Regist	ar	FEB 0 5 2004 AZER	D	sparks			

		- For State Registrar Amend Item#31pe						ealth a	and M		eg. No.	004	0324
Physicia /Medic	_	<ol> <li>Decedent's Name (First, Middle, Last)</li> <li>Joan Veronica C</li> </ol>								2. Date of Deat Month January	Day	04 <sup>Year</sup>	3. Time of Death 7:45 A M
Examine		4a. Facility Name (If not institution, give s 1208 Deanwood Road				Hi1	1end <i>a</i>				Balt		e County
Funeral Director		5. Social Security Number  210-26-1297  Usual Residence of Decedent	IM 257 E	Age (In yrs. 56	last birthday) Yrs.	Months	Days	If Under a	Min.	8. Date of Birth (Month, Day, AUG. 9, 1	. 937	9. Birth Cou Mar	place (State or Foreign Intry) y Land
5-0036 72 hours after death with the Maryland fraturel; or items 23s or 28s-1 show dieal Examiner must be notified at	ector	10a. State 10b. County  Maryland Worcester			y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
and 21215-0036  be filed within 72 hours after death with the Marylan tial Hygiene.  d other than "naturel; or floms 23a or 28a-f ehow event, the Midical Exemines must be notified at	Funeral Director	10e. Street and Number 324 Ocean Parkway 11. Marital Status	12. Was Decede	nt Ever in U	.S. 13.1		p Code 218 adent of Hi		gin? (Spe	ocify Yes or No-Rican, etc.)	14. Ra	ce - Amer	ican Indian,
0036 hours after urei', or its	d by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force  1 Yes 2 If Yes, Give  Year or Date:	No		I □ Yes	2 No	Specify:	, rueno		Speci	fy: White	ite
21215-0036 ad within 72 hours af rgiane. er than "naturei; or i, the Midical Exern	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		r 5+)	16a. Deced (Give life. I Psych	kind of wi DO NOT L	ork done d ise retired,	luring most )	of worki	ng	16b. Kind of E		•
Maryland 2121 ad 2 should be filed within lith and Mental Hygiene. 27 is marked other than " rtraumatic event, the Mar	To Be C	17. Father's Name (First, Middle, Last)  John Joseph Kiel							rs Name	(First, Middle, M t Agnes			
5 5 5 6 5		19a. Informant's Name/Relationship (Type DeSales A. Cooke	pe, Print)		324 0	cean	Parl	kway,		l <i>R</i> oute Number lin, Mar			
Baltimore, permit. Pages 1 an Department of Heal Important: If Hem? eny injury or other	i	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta		Place of Dispo cemetery, cren aney V					,2004 T	20c. Location imoniu	-	
Balt permit. Departi Importi eny inj		21. Signature of Funeral Sergica Literas	nuce	108						e of Dul Timoniu			
Pnysician /Medical	1	23a. Pari1. Enter the disease, or coordinate, control or heart failure. List only or lamediate Cause (Final disease or condition resulting in death)	ne cause on each	line.	TATI					r respiratory arre	est,		Approximate Interval Between Onset and Death
executed an and rial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence as a consequence	weribe of):								
that the death certificated by the attending price detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	ıl death 3□	Ectopic p Other (s	pregnancy					ate of deliv	rery Day Year
vequires that vequires that been signed by should be deta	ρ	Part II. Other significant conditions cor	ntributing to death	but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did tob	\.		the cause of death?
	Completed						<del></del>			24a. Was as autops perform	y l	Were autoprior to codeath?	opsy findings available ompletion of cause of
ysician ysician is certifu director	To Be	25. Was case referred to medical examiner?  1 Yes 2 X No	lospital: 1  Inpa	itient 2	ER/Outpatien	t 3 🗆 D	OA Othe			(Check only one 5 ₹ Reside		her ( <i>Speci</i>	fy)
DIVISION OF To the Hospital or Attending Physical in 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of li (Month, I	njury Da <i>y Year)</i>	28b. Time of Injury	М	28c. Injury Work		4	28d. Describe ho			
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune		4 Homicide determined	building,	etc. (Specil						City or Town	, State)		al Route Number,
To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1 N Certifying Physical (Cneck only one)	ner: Un the basis and manner	of examina	tion and/or in	estigation	at the tim	ie, date and pinion, deat	d place, a	and due to the ca	iuse(s) and mate and place,	anner as s and due t	stated. o the cause(s)
To t To t	Σ	29b. Signature and title of certifier		1		29	c. License	number 3183	3.0	25	9d. Date signe	ed (Month,	Day, Year)
G		30. Name and address of person who co								vland '	1729 21093	104	
Sta Registra	-	31. Date filed (Mopilir Day, Year)		stra 🛵 Signe			No.		مير	Lough			

	(E)
al Records, P.O. Box 68760,	The law requires that the death certificate be executed
Division of Vital	Hospital or Attending Physician: The lav

		Please Type or							
		1 = State Registrar	Marylar		artment of H rtificate of I		Mental Hygie	ene 2 () () (	0324
Physic /Medi		1. Decedent's Name (First, Middle, Last) Domingo Collazo					2. Date of Death Month February	Day Yeer 3 200	
Examin Funeral Director	ner		T. Age (In yrs.		Balti	Mo Y C  If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y JAN 13,	N/A N/A 9. Bin C 1923 Pu	oth outplace (State or Foreig ountry) erto Rico
a-f ehow	ctor	10a. State 10b. County  Maryland Baltimore		ings M					10d. Inside City Limits
ath with the s 23a or 28 sust be no	Funeral Directo	10e. Street and Number 3909 Esgarth Way			10f. Zip Code 21117		10g US	. Citizen of What C	ountry?
72 hours after death with the Maryland "naturel", or items 23a or 28a-f show idical Examinet was be notified at	by	11. Marital Status  1 XNever Married 2 ☐ Married 1 XNever Married 2 ☐ Married 1 ☐ Yes, Giv Year or Da	ces? 2 [X]No e		2 L	spanic Origin? (Sp n, Mexican, Puerto Specify: Puerto Ri	Rican, etc.)	14. Race - Am Black, Whi	
y within piene. r than	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  UNK.	4or 5+)	16a. Dece (Give life. Groot	dent's Usual Occupa kind of work done of DO NOT use retired	ation	king 16	b. Kind of Business  Horse Rac:	,
should be filed ind Mental Hygid is marked other umatic event, in	To Be C	17. Father's Name (First, Middle, Last) UNK •				UNK.	ө (First, Middle, Ma.	iden Sumame)	
Health a		19a. Informant's Name/Relationship (Type, Print)  Steven Hinds/Friend  20a. Method of Disposition  1 □ Burial 2 ☆Cremation 3 □Removal from S	tate	3909 Place of Dispo	Esgarth V	Vay Owi		s, MD 21: c. Location - City or	117 Town, State
permit. Pages Department of Important: If is any injury or o		21. Signature of John (Specify)  21. Signature of John A. Gregorch	de	22	ematory In Cremation 299 Freder	s of Facility Society	of MD, Ir	Baltimore Mc. More, MD	, MD 21228
Living and Medical Examiner  (the burial-transit	cai Examiner	23a. Part1. Enter the disease, of complications that case shock, or heart feilure. List only one cause on earn shock, or heart feilure. List only one cause on earn shock, or heart feilure. List only one cause on earn shock of cause or cause (Final disease or condition as a	used the deat	Con Cauence of):		g, such as cardiac			Approximate Interval Between Onset and Death 7 10 <b>UEST</b>
death certifi e attending id for use as	Physician/Medica		th 2 ☐ Fetal nt at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to dea	ath but not resi	ulting in the u	nderlying cause give	n in Part I.	23e. Did tobac		the cause of death?
The ate h page	Completed						24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of 2 No
ding Ph .r After th funeral	Certification; To Be	27. Manner of Death  Natural 5 Pending (Month)  2 Accident investigation  3 Suicide 6 Could not be	Injury , Day Year)	ER/Outpatien 28b. Time of Injury	28c. injury Work' M 1 \( \text{Y}	4 □ Nursing Ho at es 2 □ No	n (Check only one) me 5 ☐ Residence 28d. Describe how i	njury occurred	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determined 299. Place of building	g, etc. (Specify	vledge death	eet, factory, office	date and place	28f. Location (Street City or Town, St	tate)	
To the H within 24 To the F complete	Medical	29b. Signature and title of certifier  M.I	stated.		29c. License	number	29d.	Date signed (Month	. Day, Year)
Sta Registr			of death (Item  D  gistrar's Signat	23a) (Type, I	ospital of	Baltin	ore, 2401	West Belv	3, 200 4 Baltim
MH 17 Rev 1/20	001	FEB 0 5 2004	o St.	ORIGIN/	AL				

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				State of M	aryiano		riment of t	Health and I Death	wentai Hy	/giene Reg. No. 2	004	0324	
	· ·		1. Decedent's Name (First, Middle, Lo	est)					2. Dete of D	eeth	V	3. Time of Death	
	Physici /Medio		Deliro	h Ce	mle	$\wedge$			o i	Dey	Year O Li	5.25P1	
)	Examir		4e Facility Name (If not institution, gi	ve street end number,	) 4			4b. City, Town, or	Location of Dee	th 4c. Count	y of Death		
	۰		11511 Chapman R	oad				Kingsvi			timore	3	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. les				If Under 1 Yeer Months Days	er 1 Yeer   If Under 24 Hrs. 8. Date of Birth   9. Birthple   5 Days Hours Min. (Month, Day, Yeer)   Country   Count			lace (State or Foreign try) Yland		
	end **		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								10	Od. Inside City Limits	
	ter death with the Maryler frems 23a or 28a-1 show iner must be notified at	ŏ	MD Balti	more	Ki	ngsvil:	اه	1 ☐ Yes 27 No					
	n the	Director	10e. Street and Number		1		10f. Zip Code			10g. Citizen of	What Coun	try?	
	th wit	aD	11511 Chapman R	oad			21087			U.S.A.			
	dea in the same	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U,S	i. 13. W		Hispanic Origin? (S van, Mexican, Puert	pecify Yes or No	o- 14. Ra	ce - America		
21215-0020	72 hours efter death with the Maryland natural', or items 23a or 28a-f show dical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 If Yes, Give Year or Dates:			Tes, specify Cub		o riidan, etc.,	Speci			
	72 ho	Completed	15. Decedent's E	15. Decedent's Education y only highest grede completed)		16a. Decedent		nt's Usual Occupetion		16b. Kind of E	6b. Kind of Business/Industry		
	within ene. then "	d d	Elementary/Secondary (0-12)	(Give kind of work do life. DO NOT use ref			d)	Kilig					
7	i Hygier other th		12			Bank	Teller	40.14.11	- (F: 1 F: 1 H			dustry	
Maryland	d a b >	Be	17. Father's Neme (First, Middle, Last	,				18. Mother's Nan		e, Maiden Sumai	me)		
7	should nd Men merka umetic	မ	John Moersdorf  19a. Informant's Name/Relationship	Type Print)		19h Mailing	Address (Street	Joyce 1		ner City or Town	State 7in	Codel	
Ĕ	end 2 s saith er n 27 is er trau	- 1	Wayne A. Cunfe		n			Road - 1				_	
ē,	- I 5 =	- 1	20a. Method of Disposition	(Hubbana	20b. Pla	ce of Disposi	tion (Name of story or other pla	1	Date	20c. Location	2108 - City or Tov	•	
Baltimore,	8 = 5		1 ☐ Burial 2 【ACremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	]Removal from State fv)		•	natory,	,	2/04/0	/ Dal+i	mows	Maryland	
Ħ.	mit. Pa partmen sortant: / Injury 26.	İ	21. Signature of Funeral Service Lice		Pieci		Name and Addre					Home, P.A	
Õ	a o E a d		· So DY			117	750 Bela	ir Road -	- Kingsv	ville, M	D 21	087	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death.				_			Approximate Interval Between	
£ E	Physician /Medical Examiner	ler	Immediate Cause (Final disease or condition resulting in death)  a. Helaslatic Cervial Cauces  Due to (or as a consequence of):										
	tificete be executed g physician end es the burial-transit	edical Examiner	Sequentially hist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.										
x 68760,	entificate b ding physic se es the b	-	that initiated events resulting in death) Last  Due to (or as a consequence of):										
Вох	attend for us	by Physician/N											
P.O.	y the chiched	ysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
<u>ر</u> و	that ned b	<u>-</u>							1	Yes 25√No	3 ∐ Prob	ably 4 ☐ Unknown	
Division of Vital Records,	v requir been s should	Completed b			***				24a. Was	an autopsy ormed?	ava	re autopsy findings ilable prior to apletion of cause eeth?	
<u>~</u>	The Is ete he page	FO							10	Yes 2 No	10	Yes 2□ No	
/ita	iclan: The certificete irector, pag	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	one)	1		
7	Physic this ce	၉	1 ☐ Yes 2 ☑ No	Hospitel: 1   Inpatie		R/Outpetient		4 Li Nursing H	ome 5 Resi	dence 6 □Oth	er (Specify)	)	
Ĕ	Ing P	Ö	27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred							red			
Sic	al or Attending Physician: s after deeth. I Director: After this certification of the funeral director,	Certification:	2 Accident investigation   M   1 Yes 2 No   Suicide 6 Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number									Doute Mumber	
<u>&gt;</u>	or A after Direc	#	4 Homicide  4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Numb City or Town, Stete)									Houte Number,	
	To the Hospital or Attending Physician: The lav within 24 hours after deeth.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	S S	29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowle	edge, death o	ccurred at the tir	me, date end place	and due to the	cause(s) and ma	anner as ste	ated.	
	Ho Ho	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	f examinatio	n end/or inves	stigation, in my o	pinion, death occur	red at the time,	date and place,	and due to	the cause(s)	
	To the To the Comp	×	29b. Signature and title of certifier	1	_		29c. License number			29d. Date signed (Month, Day, Year)			
	./~	,	1 land lo	1 Au	MI	)	D an	330 79		2/2/0	4		
-	10	/	30. Name and address of person who	A			int)			1-1			
			700 S. Um	. ,	- )	Maurea	le gra	ce M	0 210	78			
	Stat Registra	٠,	31. Dete filed (Month, Day, Year) FFR 0 5 2004	32. Registro	er's Signatui	re Proof	<b>P</b>						

DHMH 16 Rev 6/95

		1 - For State Ragistrar	State of Ma		artment of Heal			ene 3. No. 2004	0325
P. D. Landini		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
Physici /Media		ELIZABETH B	ERNADETTE	CARROLL			February	2, 2004	2:40 P.
Examir		4a. Facility Name (If not institution, giv	•		4b. City, Town, or Local	ation of Death		4c. County of Dea	th
\$	*	Gilchrist Center			Towson			Baltimo	
Funeral		5. Social Security Number 6. S 216–24–5726	□ M 257 E	(In yrs. last birthday) 7/1 Yrs.		Inder 24 Hrs.	B. Date of Birth (Month, Day, ) NOV • 19,	(ear) 9. Bir	thplace (State or Fore
Director		Usual Residence of Decedent	-X	74 Yrs.			Nov. 19,	1929 Ma	ryland
land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Lim
Marylan f show	lor	Maryland N/A		Baltim	ore				1 X Yes 2 □ 1
be filed within 72 hours after death with the Maryland stal Hygiene. Adother than "natural", or tlems 23a or 28e-f show other than "natural", or tlems 23a or 28e-f show event, I'm Medical Examinar must be routiled at	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
3a or	0	5716 Charlestown	ne Drive		21212	)		U.S.A.	•
ms 2	Funeral	11. Marital Status		ver in U.S. 13.	Was Decedent of Hispan f Yes, specify Cuban, Me		ify Yes or No-	14. Race - Ame	
"natural", or Items	Fur	1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 X No	0			ican, etc.)	Black, Whit	e, etc.
E E	Completed by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2X No Sp	ecify:		Specify:	√hite
natur Ical	ted	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16	b. Kind of Business	/Industry
than "nat	nple	Elementary/Secondary (0-12)	College (1-4or 5+	life.		most or working	'		
er th	00	12 years			Homemaker			Own Home	
d other	Be (	17. Father's Name (First, Middle, Last,	)		18. /	Mother's Name (	First, Middle, Ma	iden Sumame)	
ind Mental marked o umatic eve	2	Stephen	Zamensk	i	Th	eresa	Ţ	Verner	
DU SE		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street and N	umber or Rural	Route Number, (	City or Town, State, 2	Zip Code)
n 27 n 27 er tr		Stephen W. Carrol	.1 (son	) 306 K	Kaufman Road	l Parkt	on, Mary	land 2112	20
of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	1D	20b. Place of Dispo	sition (Name of natory or other place)	Da	te 20	c. Location - City or	Town, State
int: if		1 ⊈Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		1	ley Memorial G	ardens 2	<b>-</b> 7-04 т	imonium,	Maryland
Department of Health a Important: if Item 27 is any injury or other tra		21. Signature of Funeral Service Licer	nsee						
Pep Pep Pep Pep Pep Pep Pep Pep Pep Pep		George A. Ce	Warse_	1.1	i Fene and Address of I i Fene II—Wied 5500 York Ro	bad Bal	timore,	Maryland	• 21212
hysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.	he death. Do not ent		ch as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
physician and improved the burial-transit of the burial-transit of the transit of	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c.	consequence of):					
by the attending prached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	□Fetal déath 3□	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
n signed uld be det	<u>م</u>	Part II. Other significant conditions of 6 Structure (			nderlying cause given in F	Part I.			the cause of death?
or death.  ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as th	Completed						24a. Was an autopsy performe	d? prior to death?	topsy findings availa completion of cause of
sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?			26. 1	Place of Death			
rnysic this ce al direc	10	1 ☐ Yes 2 Sto	Hospital: 1 Inpatien	t 2 ER/Outpatien	t 3 DOA Other: 4	☐ Nursing Home	5 Residence	e 6 Other (Spec	divilasoice
death. ctor: After th / the funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) 28b. Time of Injury		28	d. Describe how		100
rs after de al Directo ed in by th	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injur building, etc.	y - At home, farm, str ( <i>Specify</i> )	eet, factory, office	28	f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
vithin 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical	(Check only '2   Medical Exam	ysician: To the best of niner: On the basis of e and manner state	examination and/or inv	occurred at the time, da restigation, in my opinion	te and place, an , death occurred	d due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To t To t	Σ	29b. Signature and Itle of certifier	1 0		29c. License num			Date signed (Month	
16		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	O2520 Charles S	) 4	te	borry ?	2, 2000
		W.A. Rilay	GBMC	6201 N.	Charles &	t. Ba	Sto M	8 20 20	مكرا
	ite	31. Date filed (Month, Day, Year)	32. Registrar						

DHMH 17 Rev 1/2001

**ORIGINAL** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

COBERT CROSS

Baltimore, Maryland 21215-0036

To the Hostrital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	ľ	I. Decedent's Name (First, Mid Robert Cro	•					M	ate of Death onth	Day 25 200	Year 3. Time	
cal	4	le. Fecility Name (If not institut		d number)		4h City Town	, or Location of		luary	25, 200 4c. County		AM_
ner		Carroll Hosp				Westmi		- outil			rroll	
	5	5. Social Security Number 229-32-8676	6. Sex 1 🔯 M 2 🗆	7. Age (In yrs	. last birthday Yrs.	Months Day		Min. (M	ate of Birth fonth, Day, Y	(ear) 1932 1 <del>032</del>	Birthplace (State Country)	or Fo
	-	Usual Residence of Decedent		unk 10c.C	in Tour				· ·		1.2	
2		10a. State 10b. Coun	ny .		esburg						10d. Inside	
Director	-	VA I0e. Street and Number									1 TYe	3 -X
		807 H Edward	10f. Zip Code					/hat Country?				
era	-		20176  Was Decedent of Hispanic Origin? (Specify Yes or N 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.)			an or No	USA No- 14. Race - American Indian,					
Funeral	'	1 ☐ Never Married 2 ☐ M	Arme	Decedent Ever in l d Forces? 'es 2 ☐ No	unk	If Yes, specify Cu	iban, Mexican,	Puerto Rican,	etc.)		k, White, etc.	
by		3 □ Widowed 4 □ Divorce	. If Yes	s, Give or Dates:	dirk	1 ☐ Yes 2X N	o Specity:			Specify:	white	
			ent's Education			edent's Usual Occ			unk 16	6b. Kind of Bus	siness/Industry	u
Completed	-	(Specify only high Elementary/Secondary (0-12	nest grade complet	ted) ge (1-4or 5+)	(Give	kind of work don DO NOT use retir	ne during most o red)	of working	GIIK		,	u
Som	ι	ınk	unk	9-(1.30.07)								
Be C	1	7. Father's Name (First, Middle	e, Last)			unk	18. Mother's	s Name (First	, Middle, Ma	iden Sumame	B)	u
ToE												
		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
		Carroll Hospi	tal Cente		20	0 Memori	al Aven	ue Wes	tminst	ter. MT	21157	
	2	20a. Method of Disposition	a 3 DRamaval fr	I	Place of Dispe	osition (Name of matory or other pl		Date			City or Town, State	
		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☒ Other		rom State		,						
10a. State   10b. County   Unk   10c. City, Town or Location   Leesburg										Baltimo	re Street	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):								CCIA				
Examin	t	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
hysician/Medical Examin	d co	f any, leading to immediate cause. Enter Undertying Cause (Disease or injury hat initiated events resulting in death) Last  F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c	outcome of pregnt ve birth 2 Fett regnant at time of onknown	quence of):  quence of):  ancy al death 3[ death 5[	□Ectopic pregnan. □ Other (specify)	су			23d. Date Mont		Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State o	f Marylaı	•	artment rtificate			nd <b>M</b>	ental Hyg	iene	200	14	0325
D	avojoj		1. Decedent's Name (First, Middle,								2. Date of Dear			ar	3. Time of Death
	nysici: Medic	_	Robert Franci				1				Februar	1, 3,	200	14	6:20 A <sup>M</sup>
E	xamin	er	4a. Facility Name (If not institution, g						Location of				County of E		
Γ			Harford Memoria  5. Social Security Number 6	Sex HOSPA	7. Age (In yrs	. last birthday)	If Under		de Gra		8. Date of Birth		Harfo		ace /State or Foreign
	neral ector		176-20-4884	1 <b>X</b> )M 2□F		75 Yrs.	Months	Days	Hours	Min.	(Month, Day, Sept 15	Year)	28	Count	ace (State or Foreign try) PA
ъ.			Usual Residence of Decedent		1.0.0										
anyla	7	2	10a. State 10b. County	o		ity, Town or Lo								10	od. Inside City Limits 1 ☐ Yes 2X No
The M	1	ectc	MD Ceci-	ζ		onowin	90 101. Zip	Codo			1.	O- Civi-			
with	3	ă		and					c		'	ug. Citiz	zen of What	Count	ry r
Jeath Jeath	1 18	era	665 McCauley Re	12. Was Dece	edent Ever in L	J.S. 13.		2191 ent of Hi		in? (Spe	cify Yes or No-	1	USA 14. Race - A	merica	an Indian.
within 72 hours after death with the Maryland ene.	cal Examiner rough by roulled at	by Funeral Director	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	rces? 2 ∐ No ⁄e		If Yes, speci 1 ☐ Yes 2		n, Mexican, Specify:	Puerto F	cify Yes or No- Rican, etc.)		Black, V		etc.
hou s	Cell	ed	15. Decedent's		2100.	16a. Dece	dent's Usual	I Occupa	ation			16b. Kir	nd of Busine	ess/Ind	ustrv
ed within 72 hours affigene.	Medi	Completed	(Specify only highest : Elementary/Secondary (0-12)		-4or 5+\	(Give	kind of worl DO NOT use	k done d	turina most c	of workir	ng	, 00, 11,	10 01 000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	33.i y
d with	2	E O	Elementary/Secondary (0-12)	5			Teache	er			1	Publ	ic Hi	gh	School
id 2 should be filed the and Mental Hyg	vent,	Bec	17. Father's Name (First, Middle, La								(First, Middle, M	Maiden :	Sumame)		
Ment	atice	10	Thomas Patrio	ck Daly					Luc	ly K	elley				
12 should be filed within hand Mental Hyglene.	or other traumatic event, the West		19a. Informant's Name/Relationship								Route Number			e, Zip (	Code)
2 = 0	hert	-	Joanne Daly/Wife	2	OOL.	665 Place of Dispo			-		vingo, 1				
ges 1	or of		20a. Method of Disposition 1 ☐ Burial 2 [X]Cremation 3			comptant area	matani ar at	har alaa	9) (	02/0			cation - City		
t. Pa	any injury or once.		'4 □Donation '5 □Other (Spe		K.	T. Foa							ing Su		
permit. Pages 1 at Department of Hea	any ir		21. Signature of Funeral Service Lice	Gon	fie	1	11 Sou	ith	Queen	St,	. Foard Rising	Sun			
Pnysi	_		23a. Part). Enter the disbase, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ny one gause on e	alised the dea ach line. ER/70/		er the mode	of dying	g, such as ca	ardiac or	respiratory arre	est,		7	Approximate Interval Between Onset and Death
/Med Exam			Sequentially list conditions	b	or as a consecutive of the conse	TED	VISCE	45						ئے ا	5 das?
/ B	ısit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a consec	quence of):									
cate be executed	s the burial-transit	ai Examin	that initiated events resulting in death) Last	c. Due to (	or as a consec	quence of):									
ificate	as the	edicai		d											
70 0	tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of c	al death 3	Ectopic pre Other (spe					2:	3d. Date of Month		y Day Year
E E	8 8	by P	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did tob	acco us	se contribute	e to the	cause of death?
quires	ed bl		COPD	_							1 □ Ye	s 2 🗆	]No 3□	Proba	bly 4 Unknown
w rec	should	Completed	Cirrho	5/5							24a. Was ar	1	24b. Were	autop	sy findings available
The la	page 2	E O	**************************************	<u> </u>						_	autopsy	red?	prior death	to com 1?	pletion of cause of
	for. p	0	25. Was case referred to medical						26. Place o	f Death	1 Yes 2 (Check only one	<b>™</b> No	1,41	'es 2	- INO
Physician: The law requires t	7 =	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 1	npatient 2	ER/Outpatien	t 3 DO	Othe	APT		e 5 🗆 Reside		Other (S	pecify)	
ng Ph		Ľ.	27. Manner of Death	28a. Date of	of Injury h, Day Year)	28b. Time of Injury	28	lc. Injury Work		-	Bd. Describe ho			, , ,	
Attending r death.	the fur	atic	2 ☐ Accident investigat	ion	.,,,	,,	М		res 2 □ No						
of after of	d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place	of Injury - At h ng, etc. (Speci	ome, farm, str	eet, factory,	office		2	Bf. Location (Str City or Town	eet and State)	Number or	Rural	Route Number,
Hospital or     24 hours afte     Funeral Dire	ely fi	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the aminer: On the ba and mann	isis of examina	owledge, death ation and/or in	n occurred a vestigation, i	it the tim in my op	e, date and i	place, ar	nd due to the ca d at the time, da	use(s) a te and p	and manner place, and c	as star	ted. he cause(s)
To the within 2	ошо	Me	29b. Signature and title of certifier	0					number				signed (Mo		
			hus to a	ex m	D			1)2.	5597	>		2/2	3/04		
16	)	-	30. Name and address of person wh	o completed caus		m 23a) (Type.	Print)	VV	/			1/	7 7		, 111) 210/
l			A. P. CANLA		,		5	04	CEWIS	57	HAU	なり	E GKA	105	, 100 2101
	Stat		31. Date filed wath, Qay5 Yell	4 32. R	egistrar's Signa	ature	0° a			,	<del></del>				

DHMH 17 Rev 1/2001

DALY, ROBERT FRANCIS

			_ For	State of Maryla				Mental Hygien	e 2001	00000
		574	1 - State Registrar		Certific	cate of D	eath	Reg. N	o. 2004	03254
	Physici	ian	Decedent's Name (First, Middle, La     ADE	,	DΛN	IELS		2. Date of Death Month Di FEBRUARY	1, 2004	3. Time of Death 5:55 P M
	/Medio		4a. Facility Name (If not institution, giv				ocation of Death		c. County of Death	J 5:55 P
			HOSPICE OF BALTI	MORE GILCHRIS		TOWS			BALTIMOR	
Ì	Funeral Director			TH 000	5 Yrs.		Hours Min.	8. Date of Birth (Month, Day, Year JULY 26, 1	9. Birth Cou	place (State or Foreign http:/ ASABLANCA
	/land		Usuel Residence of Decedent  10a. State 10b. County	10c.	City, Town or Location					10d. Inside City Limits
	death with the Maryland rms 23a or 28a-f show	ctor	MD BAL	TIMORE	OWINGS	MILLS				1 Yes 2 No
	ath with the 23a or 26	Director	10e. Street and Number	COURT #C	10	f. Zip Code	01117	10g. C	itizen of What Cou	
	ns 234	Funeral	4501 SPRINGWATEI	12. Was Decedent Ever in	U.S. 13. Was E	ecedent of Hisp	21117 panic Origin? (Sp	pecify Yes or No- Rican, etc.)	14. Race - Ameri	U.S.A.
	within 72 hours after death with the Maryla nan "ratural", or items 23a or 28a-1 shov than "badical Eser-itret man be recitified at	by Fun	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:			Mexican, Puerto Specify:	Rican, etc.)	Black, White, Specify:	etc. WHITE
5	2 보	Completed	15. Decedent's E	ducation ade completed)		of work done dur	on ring most of work	king 16b. I	Kind of Business/Ir	dustry
7	be filed within 7 trail Hygiene. Ind other than "n event, the Media	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEMA	OT use retired) ピロロ				OWN HOME
2	Hygie Other ent, II	0	17. Father's Name (First, Middle, Last,		HUMLMA		8. Mother's Nam	e (First, Middle, Maide	n Sumame)	OWN HOME
<u> </u>		To B	MOSES		BENBAYAN		FLORA		DE	LMAR
	iges 1 and 2 should it of Health and Mer if item 27 is marks or other traumatic		19a. Informant's Name/Relationship (	•				ral Route Number, City		· ·
ນ໌ ຂ	1 and Health In 27 Ther tr		MILTON DANIELS /		. Place of Disposition		TER COU		NGS MILL  ocation - City or T	S, MD 21117
	ages ant of I t: If ite y or o		1 X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif	Removal from State	cemetery, crematory	or other place)	FM 2/4	/2004 R	•	
Saitimo	permit. Page Department of Important: If eny injury or once.	h	21. Signature of Funeral Service Licer			e and Address		OL LEVINSON		
Ŏ	Pen Oben yeny	١,	Day Clay	Leuis	890	O_REIST		ROAD - PIK		
			23a. Pert . Enter the disease, or comsho k, in hear failure. List only.	plications that caused the de the cause on each line.	eath. Do not enter the					Approximate Interval Between Onset and Death
8,	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Lym	<del> </del>	of th	e cen	tral nerva	200	months
	Examiner			Due to (or as a cons	equence of):			3/3/64		
	3,	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a cons	equence of):					
	ate be executed nysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
o O	be ex ician a burial	cal E		Due to (or as a cons	equence or):					
	ficate g phys			_ d						
Š	death certifica e attending ph d for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		oic pregnancy			23d. Date of deliv	
	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 Pregnant at time o		r (specify)			Month	Day Year
	The law requires that the steep that seem signed by the page 2 should be detache		Part II. Other significant conditions of	ontributing to death but not r	esulting in the underly	ing cause given	in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
cords,	quires n sign ald be	d by						1 ☐ Yes 2	No 3□ Prot	ably 4 Unknown
2	awrec is bee	Completed						24a. Was an	24b. Were auto	opsy findings available impletion of cause of
	The I	Com						autopsy performed? 1 ☐ Yes 2 ☑ N	death?	2□ No
<u> </u>	Physician: The law this certificate has tral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Other		th (Check only one)		1/
5	ding Phys n. After this of funeral dir	7.	1 Yes 2 XNo	1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatient 3[ 28b. Time of	DOA Other:	4   Nuising n	ome 5 Residence		n Hospico
SIOIS	Attending or death. ector: After by the fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work?	s 2 No		,	
DIVIS	after des after des Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At building, etc. (Spe	home, farm, street, fa	ctory, office		28f. Location (Street a City or Town, Stat		al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying Properties (Check only one)	nysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, death occu nation and/or investig	rred at the time, ation, in my opin	date and place, ion, death occur	and due to the cause(s red at the time, date an	s) and manner as s nd place, and due to	tated. o the cause(s)
	To th To th Comp	×	29b. Signature and title of certifier	1 19		29c. License n	umber	29d. Da	ate signed (Month,	Day, Year)
	_		1 C/ Anth	ony Kile	3. mo	025	205	te	propry	0,2004
	2		30. Name and address of person who	completed cause of death (It	ern 23a) (Type, Print)	les St.	Balto	Fel md 210	7.84	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	,				
	Registr	101	0 ~ 00	No.	Les .	1	7			

			1 - State RegistraAMEND ITEM #26 PE						Mental Hyg	iene <sub>19. No.</sub> 2001	03255
	Physicia /Medic	al	Decedent's Name (First, Middle, Last)  4e. Fecility Name (If not institution, give stre	Laura		Dice	embre	or Location of Deat	2. Date of Deat Month January	h Dey Yeer	3. Time of Death 5:45 A M
4	Examin Funeral Director	er	2702 McComas Avenu 5. Social Security Number 6. Sex	e 7. Age	(In yrs. Ia:	st birthday) Yrs.	Dund If Under 1 Yea Months Day	r If Under 24 Hrs		Yeer) 9. Birt	imore hplece (Stete or Foreign puntry) rginia
	ueath with the Maryland me 23a or 28a-f ehow flourit to notified at	ctor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Balti		10c. City,	Town or Lo	,	Dunda			10d. Inside City Limits 1 ☐ Yes 2∰No
	23a or 2	Funeral Director	10e. Street and Number 29 Mavista Avenue				10f. Zip Code	21222	2	Og. Citizen of What Co	ates
0000	n /z nouis alter uean win the maryar "naturel", or iteme 23a or 28a-f ehow colcal Examiner mart be notified at	by	11. Marital Status  1 Never Married 2 Married  \$\frac{1}{2}\text{Widowed} 4 \end{bryorced}	Was Decedent Ended Forces?  1 Yes 250 No. 1f Yes, Give Year or Dates:			Vas Decedent of Yes, specify Cu	Hispanic Origin? (Suban, Mexican, Puer o Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
0-0171	oe filed within 72 hours after ut all Hygiene. Jother than "naturel", or Hen	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ion o <i>mpleted)</i> College (1-4or 5+	•)	(Give life. [	ent's Usual Occ kind of work dor OO NOT use reti	e during most of wo	orking	16b. Kind of Business Own Hot	
		To Be C	17. Father's Name (First, Middle, Last) Walter Thomas Hoff	man					me <i>(First, Middle, M</i> ly Elizal	Maiden Sumame) Deth Weave:	r
Ĕ	2 = 2 = 2		19a. Informant's Name/Relationship (Type, Douglas Dicembre		on)	270	2 McCom		Dundalk,		21222
Baltimore,	permit. Pages 1 at Department of Hea Important: if item eny injury or othe		20a. Method of Disposition  1 ☒ Bunal 2 ☐ Cremation 3 ☐ Rem  4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Bet	hsaida rch Ce	sition (Name of natory or other s i United emetery	2/2	Date 2/2004	20c. Location - City or Brightwo	
Balt	Departi Departi Import eny inj once.		21. Signature of Funeral Service Licensee	Mass	sex	79	22 Wice	Funeral	indall Ma	undalk, Ir	1222
». } Е	Physician		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition	tions that caused to cause on each line	the delath.	Do not ente	er the mode of d	ying, such as cardia	or respiratory arre	est,	Approximate Interval Between Onset and Death
*	/Medical Examiner	er	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	ence of):	nory	ACCI	•		10 YEARS
/60,	icate be executed physician and s the burial-transit	cal Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):					
-	leath certificate attending physi i for use as the f		d	. It yes, outcome o	of pregnan	m.				and Downston	
O. Box	the c by the achec	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	1 Live birth 2 4 Pregnant at t	2 ☐ Fetal o	death 3	Ectopic pregnal Other (specify)			23d. Date of de Month	Day Year
Records, P.	w requires that been signed b should be deta	by	Part If. Dther significant conditions contrib	_		_		given in Part I.		os 2 No 3 P	o the cause of death?
		Completed								y prior to death? No 1 □ Yes	utopsy findings available completion of cause of
on of Vital	ding Phy n. Alter this funeral d	tlon: To Be	T Tes Z No	pital: 1   Inpatier 28a. Date of Injun (Month, Day	y :	R/Outpatien 28b. Time of Injury	28c. In	Other: 4 Nursing	1	e)  nnce 6 XX ther (Spe	SON'S RESIDENCE
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Could not be	28e. Place of Inju building, etc.			eet, factory, office	ce ·	28t. Location (St. City or Town	reet and Number or R. n, State)	ural Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	Medical (	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best o r: On the basis of and manner stat	examination	ledge, death on and/or in	occurred at the vestigation, in m	time, date and plac y opinion, death occ	curred at the time, da	ate and place, and due	e to the cause(s)
•	To the within To the comp	Σ	29b. Signature and title of certifier	TEMPINI	- P	147516		00 255		9d. Date signed (Mon	
	6		30. Narto and address of person who com	pleted cause of de	eath (Item	23a) (Type.	Print) - N	. CHARL	ES ST.	BACS.	04 W21204
	Sta Regist		31. Date tiled (Month, Day, Year)	32. Registra	r's Signati	TLO TO	de				

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			AMEND ITEM #16b PER ANA BD G828 2/04/04 JE Pertificate of Death		Reg. No. 2 (	004	03256
	Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi	cal	4a Facility Name (It not institution, give street and number)  4b. City, Town, or Lo	cation of Death	15	04 y of Death	11:13 Am
-/	Exami	ner		Socion of Bout			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt	h	gomer 9. Birthp	y lace (State or Foreign ltry)
	Director		34/163596 1 M 2DF 85 Yrs. Months Days Hours Min.	(Month, Da	y, Year) 1919	IRE	
	how		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	a Ma	cţō	MD Monta. Potomac				1 X Yes 2 □ No
	23e or 2	ral Dire	10718 Potomae Tennis Lane 20854		10g. Citizen of	What Cour	itry?
215-0020	nit. Pagas 1 and 2 should be filed within 72 hours aftar daath with tha Maryland artmant of Haaith and Mantal Hygiana. ortant: if item 27 is marked other than "natural; or items 23e or 28e-f show injury or other traumatic event; the Modical Examiner must be notified at it.	Completed by Funeral Director	11. Marital Status  1	ecify Yes <i>o</i> r No- Rican, etc.)		ce - Americ ick, White, <sup>fy:</sup> Wh	etc.
5-0	72 hc	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	ina	16b. Kind of E		dustry
2121	filed within Hygiana. ther than "	Comple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12  (Give kind of work done during most of work)  Iffe. DO NOT use refired)  professor		Prove	RSTIY	<b>→</b> F
Maryland	ould ba filk Mantal Hy arked oth	To Be	17. Father's Name (First, Middle, Last)  John Henry Doran  18. Mother's Name  Mary F	e (First, Middle, Francis		me)	
	and 2 sho aalth and n 27 is me	38	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rure 8007 Belmont Ct, M	brsha(	e u	20	115
Baltimore	Pagas 1 nant of Hi ant: If iter ury or oth		20a. Method of Disposition  1 □ Burier 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 □ Donation 5 □ Other (Specify)	1 15/04	20c. Location	- City or To	wn, State
Bait	parmit. Pa Dapartman Important: any injury.		21. Signatur of Fried Strike Scenses and Aright Strike Board Baltimore, MD 2120		Balti	nore S	Street
E			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,		Approximate Interval Between
	Physician						Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Q Cutte Corollary Voles Cut / cut	Acc	iden	1	wh.
		Je.	Due to (or as a consequence of):			1	old
	cutad nd ransit	Examiner	Sequentially list conditions.  Due to (or as a consequence of):				
ó,	ficata be axecutad physician and ts tha burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				ald
68760,	cata b	Medical	Cause (Inseed events resulting in death) Last  Due to (or as a consequence of):				, ,
×	it tha daath cartificata by tha attanding phys tachad for usa as tha	Me	d				
Bo	aath c attan for u	cian					
o	tha da y tha schad	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				the cause of death?
S, P	as that ignad b ba data	by Pi	Alghermers Disease.	1 🗆 ነ	as 2V No	3 ☐ Prop	ebly 4 ☐ Unknown
of Vital Records	requir been s should	Completed b	advanced Dementia	24a. Was a	an autopsy med?	ava	re autopsy findings illable prior to appletion of cause death?
Re	Tha law cata has paga 2	E		104	es 2 No	1	Yes 2016
ital		Bec	25. Was case referred to medical 26. Place of Death				
Ť <	<u>5 0 5</u>	70 E	examiner?  1   Yes 2   TNo	The State of the		er (Specify	)
	D) 00 00		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28c. Injury at Work?	28d. Describe h	ow injury occur	red	
sio	Attending ir daath. ector: Aftai by tha funa	catic	2 Accident investigation M 1 Yes 2 No				
Division	of or Att	Certification:	determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Numb n, State)	oer or Rurai	Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Aft complately filled in by the fur	Medical C	29a. Certiflier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a curred on the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the c ed at the time, c	ause(s) and ma late and place,	anner as sta and due to	ated. the cause(s)
	To th Withir To th comp	M	29b. Signature and title of certifier  29c. License number	7	29d. Date signe		Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-D.4		(0.)	20014
	Sta	10	A Orek SALBIUL, MD 8218WISCONSIN ACE 305 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	15elha	1019	עמי	2087
	Registi		31. Date filed (Month, Day, Year)  SEB 0 5 2004  32. Registrar's Signature				

			1 - For State Registrar	State of Maryland		artment of He tificate of D			giene Reg. No. 2	004	03257
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last	Vonaldson		4b. City, Town, or	Location of De	2. Date of Dea Month O I	Day	Year O4 ty of Deeth	3. Time of Death 19.30P, M
	Examin Funeral	er	5. Social Security Number 6. Se	ital	t birthday) Yrs.	2 11	If Under 24 Hi	rs. 8. Date of Birt (Month, Da)	Be	9. Birth	nork
	Director		Usual Residence of Decedent  10a. State 10b. County	10c. City, T		cation		4-1	1-00		10d. Inside City Limits
	or 28a-f ehow	Director	MD  10e. Street and Number		Ba1	timore 10f. Zip Code			10g. Citizen o		1 PYes 2 □ No
	illed within / 2 flours after beath with the Maryland Hygiene ther then "naturel", or Iteme 23e or 28e-f show ant, the Madical Examinar must be notified at	Funeral D	2207 N. Penrose  11. Marital Status  1 ☑ Never Married 2 ☐ Married	Avenue  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 N No	13. \	2 Was Decedent of His f Yes, specify Cubar	1223 spanic Origin? Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		JSA ace - Ameri ack, White,	
000-0	n / z nouts after death w "naturel", or iteme 23e	þ	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade)	Il Yes, Give Year or Dates:	16a. Deced	I ☐ Yes 2 1 No  Hent's Usual Occupa kind of work done di DO NOT use retired)	uring most of w	rorking	Spec 16b. Kind of		Lack
717 DI	z snould be filed within and Mental Hygiene. Is marked other then eumatic event, the Ma	e Completed	Elementary/Secondary (0-12) unk  17. Father's Name (First, Middle, Last)	College (1-4or 5+) ink	nre. 1	laborer		ame (First, Middle,		torie	S
ryland	and Menta marked imatic ev	ToB	Dudley Donal 19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (Street a		a Burley Rural Route Numbe	er, City or Tow	n, State, Zij	o Code)
, E	permit. Pages I and 2 should Department of Health and Mer Important: If item 27 Is marke eny injury or other treumatic once.		Ida Campbell/moth  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ I  4 □ Donation 5 🖔 Other (Specify,	20b. Plac cem	e of Dispo	ark Avenue sition (Name of natory or other place	1	ernon, NY	7 10550 20c. Location	n - City or T	own, State
	Departm Departm Importsr eny injui		21. Signature of Euneral Service Licens Ronald S			Name and Address ate Anato	THE PARTY OF THE P	rd 655 W. 201	Balti	more :	Street
	Physician /Medical		23a. Yert1. Enter the disease, or comp shick, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the deeth. Ine cause on each line.  a		er the mode of dying	, such as card	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
4	physician and sthe burial-transit	lical Examiner	Security list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequer  c. Due to (or as a consequer  d.							
O. DOX O	Ine law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregnance 1 Live birth 2 Fetel de 4 Pregnant at time of deat 9 Unknown	eath 3	Ectopic pregnancy Other (specify)				ate of delivitions	ery Day Year
cords, F.	uires tnat i signed by ild be detai	by	Part II. Other significant conditions co	entributing to death but not resulting	ng in the u	nderlying cause give	n in Part I.				the cause of death?
		Completed						24a. Was autop perfor 1  Yes	rmed?	were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of
VISION OF VITAL	nding Fnysician: The lantith. The this certificate has a funeral director, page 2	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation		VOutpatier Bb. Time of Injury	28c. Injury Work	r. 4 Nursing	eath (Check only on Home 5 Residence 1986). Describe h	dence 6 🗆 O		(y)
DIVIS	after dea Director I Director I in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, <i>s</i> tr	eet, lactory, office		28l. Location (S City or Ton		nber or Rur	al Route Number,
	to the Mospilei or Attending From within 24 hours after death.  To the Funerel Director: After the completely filled in by the funeral	edical C		vsician: To the best of my knowle iner: On the basis of examination and manner stated.							
	vithiu To th comp	Me	29b. Signature and title of certifier	chrimohle		29c. License		323	29d. Date sign		_
			30. Name and address of person who of VIREVDRA	completed cause of death (Item 2:		Print)		- ST B			
	Sta Regist		31. Date liled (Month, Day, Year) FFR 0 5 20	32 Registrar's Signatur							

		For State Registrar	State of Ma	-	epartment of H Certificate of I			giene 20 (	14 0325
<b>%</b>		Decedent's Name (First, Middle, Last)					2. Date of De. Month		3. Time of Death
Physic /Medi		George A. Eckart					Feb.	1, 2004	4 10:15 AM
Exami		4a. Fecility Name (If not institution, give st			4b. City, Town, or		th	4c. County of	
		Gilchrist Hospic		//m Inch hindh	Towson	If Under 24 Hrs	8. Date of Bir	Baltin	
Funeral		5. Social Security Number 6. Sex 220-22-2555	M 2□F	e (In yrs. last birth) 75 Yr	Months Days	Hours Min	. (Month, Da	0, 1928	Birthplace (State or Foreign Country) Maryland
Director		Usuel Residence of Decedent					Aug. 3	0/ 1320	
how		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
a - a	ctor	MD Howard		Woodstoo					1 ☐ Yes 2 N
oeatn with the Maryland ms 23a or 28a-f ehow	Director	10e. Street and Number			10f. Zip Code 21163			10g. Citizen of Wha	at Country?
be lifet with 7.2 hours after beauth with the waryan de lifet than "natural", or frems 23a or 28a-f show event, the Medical Exerciting must be indifficial at	rai	2130 Ganton Green	2. Was Decedent B	Ever in 11 S	13. Was Decedent of H	lispanic Origin? (9	Specify Yes or No		American Indian,
ten de	Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married	Armed Forces?		If Yes, specify Cuba	an, Mexican, Pue	no Rican, etc.)	Black,	White, etc.
tural", or ite	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:		1 □ Yes 2 No	Specity:		Specify:	white
natur lical	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(	ecedent's Usual Occup Give kind of work done	during most of we	orking	16b. Kind of Busin	ness/Industry
filed within 72 Hygiene. other than "nai	nple	Elementary/Secondary (0-12)	College (1-4or 5		ife. DO NOT use retired	d)			
Hygier ther th	Cor	17. Father's Name (First, Middle, Last)	4		Owner/Pre		me (First Middle	Metal , Maiden Sumame)	Fab.
ntal F	Be		Q					beth Enc	d and
should be ind Menta s marked umatic ev	2	George A. Eckart,  19a. Informant's Name/Relationship (Type		19b. I	Mailing Address (Street				
ith an Ith an 27 is 1		Lorraine Eckart	- wife		30 Ganton G				
es 1 and 2 should by Health and Menty I frem 27 is marked rother traumatic e		20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other place	ca)	Date	20c. Location - Cit	ty or Town, State
Pages nent of ant: If it ary or o	19	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	moval from State		vridge Mem.	1	04/2004	Elkridge	e, MD
permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licente	0		22. Name and Addre Gary L. Ka 7250 Washi	ufman Fu	neral Ho	me @ Meado	owridge MP, In 21075
Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)			of enter the mode of dying the Sylvensylves	ng, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
sate be executed why sician and the burial-transit be	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of					
the attending phy the attending phy thed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	y		23d. Date of Month	
ures that the de signed by the a Id be detached f	þ	Part II. Other significent conditions con	tributing to death b	ut not resulting in	the underlying cause giv	ven in Part I.	23e. Did 1	<b>*</b>	ute to the cause of death?
I he law requires that the sate has been signed by th page 2 should be detache	Completed						24a. Was auto perfo 1 Yes	psy pric	re autopsy findings availated to completion of cause c
	BeC	25. Was case referred to medical examiner?					eath (Check only		
ding Phys h. Atter this funeral di	ုင	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	ospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da		me of 28c. Injury Wo	rv at		dence 6 Other how injury occurred	
2 # # 5	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	iury - At home, fan c. (Specify)	m, street, factory, office			Street and Number wn, State)	or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	edical	29a. Certifier (Check only one) 1 Certifying Physical Exemits	icien: To the best ner: On the basis o and manner st	f examination and	death occurred at the ti for investigation, in my o	me, date and place opinion, death oc	ce, and due to the curred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title a certifier		10	29c. Licens			29d. Date signed (	
1		1 Al Indi	how, A	hle	, mo 0)	Solds		rebrua	n 1,200
		John Ville	/	and in				-	
9		30. Name and address of person who co	GBN	1C 62	Type, Print)	harles.	St. Bo	Cto. on.	1 21205

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death  Reg. No. 2004 0325	9
Physicia		1. Decedent's Name (First, Middle, Last)  NORINE A. ESTES  2. Date of Deeth Month Dey Year 02 - 01 - 2004 9:00 PM	-
/Medic		4a Facility Name (If not institution, give street end number)  4b. City, Town, or Location of Death  4c. County of Death	_
		603 CRANBROOK ROAD COCKEYSVILLE BALTIMORE	
Funeral Director		5. Social Security Number  6. Sex 1 M XXF 95 Yrs.  6. Sex 1 D M XXF 95 Yrs.  6. Sex 1 D M Months 1 Deys 1 Under 24 Hrs. 1 D M Months 1 Deys 1	ın
the Marylend 28a-f show notified at	tor	10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ND. BALTIMORE COCKEYSVILLE 1□Yes XXINO	
oth with the Maryle 23a or 28a-f show	Funeral Director	10e. Street end Number 603 CRANBROOK ROAD, APT. H 21030 10g. Citizen of Whet Country? U. S. A.	
020 urs efter dee all, or flems	<u>۾</u>	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1  Never Married 2 Married  3  Widowed 4 XXDivorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 XX Vo. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indien, Black, White, etc.  1  Yes 2 XX Vo. Specify: Specify: WHITE	
15-(	letec	15. Decedent's Education (Specify only highest grade completed)  16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  LORD BALTIMORE	
212: 3 within jiene. Than	To Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)  11 YEARS  College (1-4or 5+)  MANAGING SUPERVISOR  LORD BALTIMORE  LAUNDRY	
nd illed	Be C	17. Fether's Neme (First, Middle, Lest)  18. Mother's Name (First, Middle, Maiden Surname)	
Maryland d 2 should be file th end Mentel Hy ?? Is merked othe treumetic event	2	JOHN BREWSTER YOUNG AMELIA, ROSE VIOLET	
Mai od 2 sh ith end 17 le m	1	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)  603 CRANBROOK ROAD, COCKEYSVILLE, MARYLAND, 21030	
of Hea	-	20a. Method of Disposition  20b. Place of Disposition (Name of Dispositi	=
Baltimore, Maryland 212: permit. Pages 1 end 2 should be filed within Department of Health end Mentel Hygiene. Important: If Item 27 is merked other than any Injury or other traumatic event, The Monce.		1)CXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  MORELAND MEMORIAL PARK 02-05-2004, PARKVILLE, MD., 21234	7
Ball permit Depart Import any Inj ponce.		21. Signature of Funeral Service Licensee  RUCK TOWSON FUNERAL HOME, INC., TOWSON, MD., 21204	
		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset end Death, or heart failure.	
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  e. Myscarchial Tryanton munitor.	
	ē	Due to (oy as a consequence of):	
ocuted and transit	amir	Sequentially list conditions,  Due to (or es a consequence of):	
68760, ificete be exe g physician e	edical Examiner	Sequentially list conditions, large leading to 4 an endance cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or es a consequence of):  Due to (or es a consequence of):	
c 68760, writicete be executed ing physician and e es the bunel-transit	Medic	resulting in death) Last	
that the death certified by the attending detached for use e	clany	d.	
P.O.	nys.	Part II. Other significant conditions contributing to death-but not resulting in the underlying cause given in Part I.  23b. Did tobscco use contribute to the cause of death-	
S, P	<u>}</u>	Denece Jamerica Jacobi 4 Dillion	"
Division of Vital Records, P.O. Box or attending Physician: The lew requires that the death cerefier death.  Director: After this certificate hes been signed by the attendir in by the funeral director, page 2 should be detached for use	Completed by Physician/M	Dehydration Machinity 24a. Was an autopsy performed?  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of deeth?	
I Re	E	CCA. Seinne dis	
Vital Relicion: The legentificate he rector, page	n n	25. Wes cese referred to medical examiner?  Hospital:   General Check only one   Control of the control of the	
Vision of Vita Attending Physician: r death. ector: After this certifica by the funeral director,	2	27. Manner of Death 28e. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	_
ion ndlng fath.	atio	MXNetural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	
or Atte	בודוכ	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State)	_
Division  To the Hoapital or Attendin within 24 hours efter death. To the Funeral Director: Alt completely filled in by the fur	edical Certification:	29a. Certifier (Check only one)  Will Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.    Check only one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)	_
To the vithin To the compl		29b. Signature and the of certifier 29d. Date signed (Month, Dey, Year)	_
		Slepton Myst MV). DES 536ZZ FEBRUARY 3, 2004	
<u></u> り		30. Name end endress of person who completed cause of death (Item 23e) (Type, Print).  STEFFAN, ELTOROTH, Met). 4994 BEAVERBROCK RD., Cohumbia, MIS	
State Registra	-	31. Date filed (Month, Day, Year)  32. Registrate Signature	

			For State Penistrar Amond The #10	State of Marylan	d / Departm 2/5/04 tal	ent of Ho	ealth and M		the same of	03260
			Registrar Amend Item #10  1. Decedent's Name (First, Middle, Last,		3 Cortine	ato or E	704177	2. Date of Death	g. No.	3. Time of Death
	Physici /Medi		Pea	au D. EIK	erson			February	Day Year 2004	11:10 PM
7	Examir		4a. Facility Name (If not institution, glva	street and number)		City, Town, or	Location of Death	1	4c. County of Death	1
			Holy Cross	Hospital		Silver	Spring		Montgo	mery
	Funeral Director		5. Social Security Number 6. Sec. 577-90-4918	x 7. Age (In yrs. I ☐ M 2☑ F	Mon	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	_ (Month, Day,	Year) Cou	place (State or Foreign intry)
			Usual Residence of Decedent		110			June 18,	1956 Mass	achusetts
	hours after death with the Maryland tural', or items 23a or 28a-f show al Exantirist trust be notified at		10a. State 10b. County	10c. City	, Town or Location					10d. Inside City Limits
	B Maria-f	ctor	Hitchington, D. C.		Washine	iton -	D.C.			1 <b>⊠</b> Yes 2 □ No
	or 28	Director	10e. Street and Number		10f	Zip Code		10	g. Citizen of What Cou	intry?
	s 23a			cct N.E. #L	+	2000			USA	
	items	Funeral	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13. Was D If Yes,	ecedent of His specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
336	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 □ Y€	s 2🛭 No	Specify:		Specify: 121	ack
21215-0036	d within 72 hours after death with the Marylan piene. r than "natural", or items 23a or 28a-f show the Mudical Examilise must be notified as	Completed	15. Decedent's Edu	cation	16a. Decedent's	Usual Occupat	tion	116	5b. Kind of Business/Ir	dustry
215	within 7 ene. than "r	ıple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			tion uring most of worki	ng		·
	filed wi Hygien ther th	Co	12		Ho	use Ke	eper	4	Private Re	Sidence
und	be fill H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
Z	a Menta narked natic ev	은	Unknown				regg		ElKerson	
Maryland	s 1 and 2 should be filled if Health and Mental Hyg item 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (Ty Gary Crawford - Hu						City or Town, State, Zip	
	1 an Heal tem 2		20a. Method of Disposition	20b. Pl	ace of Disposition	Name of	D	washing	ton D.C. 2 c. Location - City or To	OWN State
ПO	eg = ± 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, crematory	or other place,	1 2-5		Hexandria	
Baltimore,	permit. Page Depertment of Important: If any njury or once.		21. Signature of Funeral Service License		opolitan Cr	e and Address	of Facility		HEXUNATION	ringinua
ñ	Deporting any series		Robert B.	Balen gr.	Chinn	Funeral	Service 21	05 S. Shid	inaton Rd Arti	nglon, Va 22206
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death	. Do not enter the r	mode of dying,	such as cardiac o	r respiratory arres	ι,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Annx	ic Fr	reeph	alo path	nU		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	700	are part	)		Day 3
	Cxammer		Sequentially list conditions, if any, leading to immediate	2	epsis	)				Days
7	lei 1sit	ulne	of any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):					
/	al-tra	Examine	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
8760,	that the death certificate be executed by the attending physicien and detached for use as the burial-transit									
9	ificati g phy as the	edic								
Вох	ih cer endin r use	N/UE	200: Was docodon program	3c. If yes, outcome of pregnan					23d. Date of delive	ery
E	a deal	sicie	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of de		c pregnancy (specify)			Month	Day Year
P.O.	Attending Physician: The law requires that the death certific rideath: rideath: ector: After this certificate has been signed by the attending pector: After this certificate has been signed by the funeral director, page 2 should be detached for use as	Physician/Medical	9 Unknown							
Ś	signed I		Part II. Other significant conditions con	itributing to death but not resul	lting in the underlyir	ig cause given	in Part I.		cco use contribute to the	
Vital Record	w requir been si should	Completed by						1 Yes	2 No 3 Prob	ably 4 🛭 Unknown
3ec	e law has b	d m	Chronic Kenal	Insufficie	ency			24a. Was an autopsy	prior to cor	psy findings available apletion of cause of
a	ician: Th certificate rector, pag		Coronary Art	ery Discas	se			performe 1 X Yes 2 □		2□ No
5	scerti	o Be	25. Was case referred o medical examiner? 1 ☐ Yes 2 ☑ No H	ospital:	700	Other	26. Place of Death			
Division of	g Physe er this eral dir	-	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury a Work?	4 U Nursing Hom	se 5  Residenc 8d. Describe how	e 6 Other (Specif)	/)
o	ath. r: Aft	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M		s 2 🗆 No		,,	
<u>×</u>	l or Atte after de Directo I in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, fac	tory, office	2	8f. Location (Stree City or Town, S	et and Number or Rura	l Route Number,
	Hospitel or Attending is 4 hours after death. Funeral Director: After tely filled in by the funeral									
	To the Hospital or Attending Physician: The la within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1  Certifying Phys (Check only one) 2  Medical Examin	ilcian: To the best of my know ler: On the basis of examination	rledge, death occurr on and/or investigat	ed at the time, ion, in my opin	date and place, ar	nd due to the caus	se(s) and manner as st	ated. the cause(s)
	To the To the Complet		29b. Signature and title of pertifier	and manner stated.		29c. License n				
•	F \$ ⊢ ŏ		1 The Indian	A AAA	1				Date signed (Month, I	
	1	1	3 ame and address of person who cor	mpleted cause of death (Item	23a) (Type Print)	レンと			02-04-	04
			Suresh K. Gur	ota MD 95	301 Geor	aid Avo	Suite 22	O Silvers	02-04- Spring, Md.	20902
	Sta	~	31. Date liled (Month, Day, Year)	β2. Registrar's Signatu	ие 🔏	4(2)		21.161	J. House	
	Registra	:17	rrn u v	Man A A A A A A A A A A A A A A A A A A A	29					

		State of Ma	aryland / Dep <i>Ce</i>	artmer rtifica				Reg. No. 2	004	0326
Physician /Medical	1. Decedent's Name (First, Middle, Las John Howard		MD.				2. Date of D Month Februa	ry 04,	2004	3. Time of Death 12:50 P
Examiner	4a Facility Name (If not institution, give	street and number)			4	•	or Location of Dea		nty of Death	
	Stella Maris	7.40	a (la con la se biobado o	If I Inde	r 1 Year	Timoni			ltimore	
Funeral Director	218-03-4054	ex 7. Agi	e (In yrs. last birthday 86 Yrs.		Days		in. (Month, D	22, 19	17 Mai	place (State or Forei ntry) ryland
within 72 hours effer beam with the Maryland than "natural", or items 23a or 28a-1 show he Medical Examinet must be notified at impleted by Funeral Director	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					1	10d. Inside City Limi
1 sho	Md. Baltimor	re	Glen Arm							1□Yes 2√√N
100	10e. Street and Number				Code			10g. Citizen	of What Cour	ntry?
Sa o	11630 Glen Arm				210	57			USA	
Important: if liem 27 is marked other than "natural", or liems 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1X Yes 2 N If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 ☐ Yes		ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	1	Race - Americ Black, White, ecify:	
tural B De	15. Decedent's Ed		16e Dece	dent's Usa	al Occupa	ation		16b. Kind o	f Business/In	dustry
than 'na he Medic omplete	(Specify only highest gra	College (1-4or 5	(Give	kind of we DO NOT	ork done d ise retired	during most of v	working		th Car	
T O	17. Father's Name (First, Middle, Last)					18. Mother's N	Name (First, Middl	e, Maiden Sun	name)	
atic ev	John Franz					Kathe	erine La	mmers		
L	19a. Informant's Name/Relationship (7	Type, Print)		_			Rural Route Num		wn, State, Zip	Code)
any injury or other tra once.	Mr. John Franz, Jr	r./ Son				en Arm,	, Md. 210	)57		
É	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	osition (Na matory or	me of other plac	e)	Date		on - City or To	own, State
	4 □ Donation 5 □ Other (Specify		Hilltop	Serv	ice C	0.	2-6-04	Towso	n, Md.	
any in	21. Signature of Funeral Service Licen	See	- 1	Ruck	Tow		neral Hom Towson, M			
dical miner	Immediate Cause (Final disease or condition resulting in death)	a. PROSTA	TE CANCER Due to (or es a conse	quence of)	:				1	Onset and Death
buriel-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	c	Due to (or es a conse	quence of)	:					
igner by the attending physician end be deteched for use as the buriel-trensit by Physician/Medical Examir	that initiated events resulting in death) Last	d	Due to (or as a conse	quence of)						
d for u	Part II. Other significant conditions of	ontributing to death h	ut not resulting in the	anderlying.	cause niv	en in Part I	23h Die	i tohacco use	contribute to	o the cause of deat
deteched for use e	Part II. Other significant conditions of	onthouting to death o	of not resulting in the	muenying	cause givi	en in Facti.				bably <b>%</b> Unkno
eted					_			s an autopsy formed?	av	fere autopsy findings vailable prior to empletion of cause death?
Page 2:							10	Yes 2 <b>X</b> N	1[	☐Yes 2☐ No
Be C	25. Was case referred to medical examiner?					26. Place of I	Death (Check only	one)		
To I	1 Yes 2 No	Hospital: 1 ☐ Inpatie				4 U Nursin				y) HOSPICE
atlon:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year) 28b. Time Injury	of M	28c. Injun Worl 1 □	yat k? Yes 2 □ No	28d. Describe	how injury oc	curred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, etc	ury - At home, farm, s c. (Specify)	treet, facto	ry, office			(Street and Ni own, State)	umber or Rure	al Route Number,
completely filled in by the funeral director.  Medical Certification: To Be (			of my knowledge, dea exemination and/or inted.							
completely filled in by the	29b. Signature and title of certifier			29	c. License	e number		29d. Date si	gned (Month,	Day, Yeer)
1		- /A-	-		Du	1372	25	2	1410	4
/	30. Name and address of person who	completed cause of d	eath (Item 23e) (Type	, Print)						
/	DR. TARIQ MAHMO	OD 2300 I	HIANEY VA	LEY	RD 🛹	TIMONI	UM, MD 2	1093		
State	31. Date filed (Month, Day, Year)	5 2004 Registr	als Signature	F	the tole					

			For Stete Registrar		State	of Maryla		artment <i>rtificate</i>				lental Hy	giene Reg. No.	2001	. 03263
	Physicia	an	Decedent's Name (First, M     Lawrence A		,		_					2. Date of De Month January		Year 2004	3. Time of Death 1:09 PM M
	/Medic Examin		4a. Facility Name (If not institu	tion, give	e street and n			4b. City, To	own, or	Location	of Death	January		county of Dea	
			Atlantic Ge 5. Social Security Number	nera 6.5			s. last birthday	Berl:		If Under	r 24 Hrs.	8. Date of Birt	in .	lorcest	er hplace (State or Foreign
	Funeral Director		171-28-4492		M 2□ F		9 Yrs.		Days	Hours	Min.	Month, Da	, Ye <i>ar)</i> 193	4 Pen	nsylvania
	D >		Usual Residence of Deceden 10a, State 10b, Cou			11mlr 100 (	City, Town or L	nontion							10d. Inside City Limits
	Manyla f shov	ō	DE TOD. CO.	y		ulik 100.	Frank								1 Tes 2 No
	be filed within 72 hours after death with the Maryland ital hygiene. d other than "natural", or itams 23s or 28s-f show event, the Modical Examination and be notified.	by Funeral Director	10e. Street and Number 116 Whisperi	ng La	ane			10f. Zip C	Code	199	75		10g. Citiz	on of What Co	puntry?
10	after death	Funera	11. Marital Status 1 ☐ Never Married 2X	Married	Armed F 1 ☐ Yes	2 X No	U.S. 13.					ecify Yes or No Rican, etc.)	. 14	I. Race - Ame Black, Whit	
Maryland 21215-0036	hours at tural', or	ed by	3 ☐ Widowed 4 ☐ Divor	ced	If Yes, G Year or	ive	16a, Dece	1 Tes 2		Specify	:: 			Specify: W	
1215	be filed within 72 ho ital Hygiene id other than "natu event, try Maulcal	Completed	(Specify only his Elementary/Secondary (0-1)	hest gra	de completea	(1-4or 5+)	(Give	kind of work DO NOT use	done d retired	lurina mo	st of work	ing			
q 9	e filed within II Hygiene. other than '	о Со	17. Father's Name (First, Mid					audito	or T	18. Moth	er's Nam	e (First, Middle,			Pennsylvania
<u>lan</u>	12 should be fi h and Mental H 7 Is marked ot Iraumatic ever	To Be	Raymond Le	ster	Frank					Nan	nie 1	Mae Dix	on		
lary	2 short and h		19a. Informant's Name/Relat		-		1	•				al Route Numbe	-		Zip Code)
ě	1 and Health am 27 Ithar to	8	Patricia Pula	iski/	daught		. Place of Disp	osition (Name	of of	- 1	2.5	isburg. Date		17112 ation - City or	Town, State
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		1 Burial 2 Cremat  4 Donation 5 Othe	r (Specif	y)	State	cemetery, cre								
Bal	permit Depar Impor any in		21. Signature of Funeral Sen RODA I	ice Sicer	Wade	Megt	or S	tate A tate A altimo	nate re,	omy I	Boarc 2120	655 W.	Bal:	timore	Street
			23a. Part1. Enter the disease shock, or heart failure.	or com List only	plications that one cause on	caused the de each line.	eath. Do not er	ter the mode	of dyin-	g, such as	s cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a. A	(or as a cons	M (								
	Examiner		Commentally the sending	1	h Ph	elly	ست								
	De its	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Union, ing Cause (Disease or injury	Į	ue to	(or as a cons	equence of):								
703	xecute and al-tran	Examiner	that initiated events resulting in death) Last	1	c. Due to	o (or as a cons	equence of):								-
0928	icate be executed physician and s the burial-transit	dical E		l	_ d				-						
4497 12064 Box 6	ath certif attending for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No		1⊡Live 4⊡Preg	utcome of precipitation of precipitation of the pre	etal death 3	⊒Ectopic pre					23	d. Date of de Month	livery Day Year
P. 0.9	that the de ed by the detached	Phys	9 ☐ Unknown  Part II, Other significant con	ditions -	9⊡ Unk		requiting in the	undosh ina an		n ia Dart	1	23a Did te	20 116	e contribute to	the cause of death?
17/-	w requires that been signed should be de	ed by	ran II. Other significant con	unions o	.onthouting to	ueatii but iiot i			use 9146	311111111111111111111111111111111111111		1	/es 2□		robably 4 Unknown
₹ <sup>2</sup> ⁄ <sub>8</sub>	The law requate has been page 2 shoul	Completed												death?	utopsy findings available completion of cause of
77.77 1/93 Vital	sician: T certificat rector, p	Be	25. Was case referred to me examiner?	dical	Hospital:				Othe	25		h (Check only o			
3/0	ding Phys n. After this funeral di	n: To	1 Yes 2 No 27. Mann of Death		28a. Date	e of Injury	☐ ER/Outpatie		c. Injury World	4 🗆 14	lursing Ho	me 5 Residente 128d. Describe 1			cify)
sion of	ttanding death. ctor: After y the funer	atio	Z Accident	estigation	n i	nth, Day Year,	) Injury	М		Yes 2□	]No				
CWRENCE DOB F. Division	Hospital or Attanding Physician: 14 hours after death. Funaral Diractor: After this certificately filled in by the funeral director, I	Certification;	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide de	uld not b	200. Flat	ce of Injury - Alding, etc. (Spe	t home, farm, s ecify)	reet, factory,	office			28f. Location (S City or Tox		Number or Ri	ural Route Number,
~	To tha Hospital or Atta within 24 hours after de To tha Funaral Diracto completely filled in by th	edical C			niner: On the							and due to the red at the time,			s stated. e to the cause(s)
	To tha within 2 To tha comple	Me	29b. Signature and the of ce	tifier	. 0					number 612				signed (Mont	h, Day, Year)
			30. Name and address of pe	son who	completed car	use of death (I	tem 23a) (Type	Print)				_ N.		ا ا م	
	Sta	ite.	31. Date filed (Month, Day, Y	ear)	32	Registrar's Sig	gnature	rinh	7	21	xxIL	my my	أكمه	841	
	Registr		FEB 0	5 20	04	All stand	B A	ask)							

AND	ACE SUS	SAN	GRIFFIN  1 - For Amen Registrar Unpe	d Ite	m#1;	ate of Ma Per 1	arylar IE, G	d/Depa	artmen	t of H	ealth a	and M	fental Hyg	iene	200	t t	032	264
			1. Decedent's Name (Fi	rst, Middle, La	ast)	.,,	91	, m. j 0020 j	<i>J</i> /4/04	9			2. Date of Dea Month				3. Time of	
4	Physici /Medi		Candace Su	ısan Gr	iffi	.n							JAN.	30,			0954	A <sup>M</sup>
	Examir	ner	4a. Facility Name (If not	_							Location				County of E			
			712 HYDE  5. Social Security Numb		DRIVI Sex		a (In vre	last birthday)	GL]		JRNIE		9 Date of Birth		NNE A			
	Funeral Director		214-56-0292		1 ☐ M 2		55	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Jan 3,	Year) 1949			ce (State or y) exico	roreign
Y ).			Usual Residence of Dec										Jan J	± / <del>4</del> .	) INC	W II	EXICO	
	arylar	-		o. County ine Arti	ndo1			ty, Town or Lo n Burn								100	d. Inside City	
	with the Maryland a or 28a-1 show be notified at	Director	10e. Street and Number		mueı		GIE	n burn		Ondo				0 00			1 🗆 Yes	2 <b>X</b> 1N0
	With With	ā	712 Hyde F		ive				10f. Zip	061				USA	zen of What A	Countr	<b>y</b> ?	
	death with the Maryland one 23s or 28s-1 show	Funeral	11. Marital Status		12. W	as Decedent I	Ever in U	.S. 13.			spanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - A	mericar	n Indian,	
9	after or Ite	Ē	1 Never Married	2 Married	1 {	med Forces? ∃Yes 2 <b>X</b> ]N Yes, Give	10						Rican, etc.)		Black, V			
8	72 hours after "natural", or ite	d by	3 ☐ Widowed 4 ₩☐		Ye	ar or Dates:			¹ □ Yes		Specify:		- 4		Specify:	wnı	te	
15-	n 72	Completed		Decedent's E				16a. Deced	lent's Usua kind of wo DO NOT us	rk done d	lurina mos	t of worki	ing	16b. Kii	nd of Busine	ss/Indu	stry	
212	filed within I Hygiene. other than *	mo du	Elementary/Secondar	y (0-12)	Co	ollege (1-4or 5 2	+)		rse	, , , , , , , , , , , , , , , , , , ,	,			7	(edica	1		
br	e filed Il Hygid other	0	17. Father's Name (First	, Middle, Last	1)						18. Mothe	er's Name	(First, Middle, i					
/lar	uld b Menta Menta arked	To B	V.I. Galla	her							San	ra Ca	atherine	McI	Kee			
Maryland 21215-0036	es 1 and 2 should be filed of Health and Mental Hygie of Health and Mental Hygie litem 27 is marked other rother traumatic svent,		19a. Informant's Name/			•	• .						Al Route Number				ode)	
	ges 1 and 2 it of Health If item 27 i or other tre		Tammy Griff		man	/ Daug					-		Sparks,					
Baltimore,	Pages 1 nent of H ant; If ite ury or ot		20a. Method of Dispositi 1 □ Burial 2X Cri 4 □ Donation 5 □	emation 3 [		al from State	Ch	Place of Dispo cemetery, cren esapea	sition (Nan natory or o ke Cr	ne of ther place emat	ion I				cation - City Jensvi			
Balt	permit. Pag Department Important; I any injury o		21. Signature of Fudera	LService Lice	nsee	M012		22	Name an	d Addres	s of Facilit	y Sir	ngleton Glen Bu	Fune rnie	eral H	lome 210	PA 61	
			23a. art1. Enter the o. shock, or hear fail	ease, or com	plication one cau	s that caused se on each lin	the deat	h. Do not ente	er the mode	e of dying	, such as	cardiac o	r respiratory arri	est,		lr.	oproximate nterval Betw	een
	Physician		Immediate Cause (Fina disease or condition	1	_ M	ultiple	Drug	Intoxica	tion								Inset and De	eath
	/Medical Examiner		resulting in death)			Due to (or as	a conseq	uence of):										~
	P #	Iner	Sequentially list condition if any leading to immediate. Enter Underlying Cause (Disease or injury)	ons, liate	b	Due to for as	a cons	uence of:										
	rate be executed obligation and the burial-transit	Examiner	that initiated events resulting in death) Last		c.	Due to (or as a	e concer	uanco of):			_					-		
8760,	be ex	Ical E		- [		308 (0 (0) as a	2 0011364	uence or).										
687	certificate Iding phys	edic			_ d													
Вох	leath certifica attending ph I for use as th	n/M	IF FEMALE: 23b. Was decedent pred	gnant		es, outcome		-,						2	3d. Date of	deliverv		
	death he atten ed for u	Physiclan/Med	in the past 12 mont	ths?	4[	Live birth Pregnant at Unknown			Other (spe						Month	Di	ay Ye	ar
P.0	ires that the de signed by the a l be detached f	Phy	9 Unknown															
Records,	w requires the been signed should be d	þ	Part II. Other significant	conditions (	contributii	ng to death bu	it not resi	ulting in the ur	iderlying ca	ause give	n in Part I.		23e. Did tob	s 2		to the Probab	w.	
oce	aw S S S	Completed											24a. Was a		24b. Were	autops	y findings av	allable
<u>~</u>	ate pag	E O											autops perform	ned?	death	?	letion of cau ⊒No	ISO OT
Vital	ilcien: Th certificate rector, pag	Be	25. Was case referred to examiner?	medical								of Death	(Check only on					
of	Attending Physicien: r death. ector: After this certific. by the funeral director,	70	1∑ Yes 2 No 27. Manner of Death		Hospita	1 L Inpatier		ER/Outpatient	-		→ □ IAU		ne 5 Reside			pecify)	AT SCI	INE .
Division of	ding h. After funer	tlon	1 Natural 5	Pending investigatio	f	Date of Injur (Month, Day Ount	Year)	28b. Time of	M	Bc. Injury Work	at ? es 2 <b>™</b> 1		28d. Describe ho <b>Unknown</b>	w injury	occurred			
İSİ	Attendii death. ctor: A y the fu	fica	and the second second	Could not b	9 200	1/30/04 . Place of Inju	ry - At ho	9:45 ome, farm, stre	a		63 2 1	2	28f. Location /Str	eet and	Number or	Rural R	loute Numbe	37
á	alor / s after I Dire d in b	Certification;	4  Homicide	Geterminen	- 1	building, etc	. (Specif)	V)	,,				712 Hyde	State) Park	Dr.,G1	en Bi	mie,	MD
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 (Check only one)	Certifying Ph Medical Exar	nysician: miner: Or	To the best of	f my kno examina	wledge, death	occurred a estigation,	at the time in my opi	e, date and inion, deat	d place a	and due to the ca	uco/e) s	and manner	ac etate	<b>Z1061</b>	
	To th withir To th compl	Me	29b. Signature and title	of certifier					29c.	License			29		signed (Mo			
			1 The	done 11		4: ~				0.0	.M.E			JAN	v. 31	., 20	JU4	
			30. Name and address of	person who		ed cause of de	ath (Item	23a) (Type, F	enn S	tree	t, Ba	altin	ore, Ma	ryla	and 21	201		
94	Sta		31. Date filed (Month, Da	ay, Year)	1	32. Registra	r's Signa											
	Registr	ar	FFR 0 5	2004	A	andra	_/	y of	ook									

	NA	⊞ Ba	NAME KNOWN TO PHYSICIAN: GREY, JENE E.  Baltimore, Maryland 21215-0036	음 <b>호</b> :		IXS]	212	15-0	3REY 036		JENE	ഥ :	
hysicia /Medic	8.5	Depa Impo	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Innoprtant: If teem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exeminar must be notified at	and 2 lealth a m 27 is	shoul nd Me mark	d be til ental H ked ott	led withir lygiene. her than it, the M	n 72 h "natu adical	ours afte rai', or it Exercin	r dea	in with the	e Man	yland now

**Funeral** Director

	and the state of t
Permit. Pages 1 and 2 Department of Health Moportant: if them 27 eny injury or other free conce.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
Baltimore, M	Division of Vital Records, P.O. Box 68760,

•	For State Registrar					ertificate of				Reg. No	2004	03265
an	Decedent's Name	(First, Middle, Las	st)						2. Date of D  Month	Da	y 3, 2004	3. Time of Death 08:00P M
al	JENE E. 4a. Fecility Name (If r.		e street and nu	mher)		4b. City, Town,	or Location	of Death	FEDROF		County of Deat	
er	VA MARYLAI					PERRY P		0. 000			ECIL	
	5. Social Security Nur	mber 6. S	ex	7. Age (In yrs	. last birthda	y) If Under 1 Year	If Under		8. Date of B			hplace (State or Foreign
	410-48-0	6836	RM 2□F	67	Yrs.	Months Days	Hours	Min.	0.4 - 2.1			IN
	Usual Residence of D	Decedent			ity, Town or	Location						10d. Inside City Limits
_		10b. County WAY	ANT ET	100.0		ROIT						1 D Yes 2 □ No
Director	MI		. N.E.		DE.	10f. Zip Code				10a Ci	tizen of What Co	nuntry?
	10e. Street and Numb	ЭӨГ								109.01		, and y
erai	4213 JEJ 11. Marital Status	FFRIES	FWY 12. Was Dec	edent Ever in	U.S. 1	3. Was Decedent of ff Yes, specify Cut	8208 Hispanic Or	igin? (Spe	acity Yes or N	0-	USA 14. Race - Ame	rican Indian,
Funerai	1 Never Married	d 2 Married	Armed Fo	rces?					Rican, etc.)		Bfack, Whit	e, etc.
þ	3 ☐ Widowed 4	Divorced	Year or D	ve ates:		1 ☐ Yes 2 🗙 №	Specify	:			Specify:	BLACK
Completed	(Specifi	15. Decedent's Ed	ducation ade completed)		16a. De	cedent's Usual Occu	pation during mos	st of worki	ing	16b. H	(ind of Business/	Industry
	Elementary/Second	, , ,	Coffege (	1-4or 5+)		ve kind of work done . DO NOT use retire						
,	12				ME	AT PACKE	1	ada Nama	(First, Middle	FOC		STRY
2	17. Father's Name (F						18. Moth				i Sumame)	
	EDWARD I				10h 14	iling Address (Stree	t and Mire		SIE G		or Town State	Zin Cade)
ı	19a. Informant's Nan				190. M	era conservative						ip Code)
	LESLIE (		AUGHTI		478 Place of Dis	기술 Shamr	ock A	AVE,	Balt.	20c. L	ocation - City or	21206 Town, State
	1 ဩBurial 2 □	Cremation 3	Removal from	State		rematory or other pla		2 11	0.4	24.7	, DVT 3 NC	
	`4 □Donation 5				ARRI	SON FORE		2-11			ARYLAND	
	11/100	1080	Cour	nezh	~	22. Name and Addr						MD 21207
$\dashv$	23a. Part i. Enter the	disease, or com	plications that	caused the dea							DALLO.	Approximate
	shock, or heart fmmediate Cause (F	failure. List only	one cause on	each line.			J.		, ,			Interval Between Onset and Death
	disease or condition resulting in death)					ACCIDENT	1					UNKNOWN
		- 1	Due to	(or as a conse	equence ot):							
e	Sequentially list cond is any, leading to limit	rediate	b. Due to	(or as a conse	quanca of).							
Examiner	cause. Enter Underh Cause (Disease or in that initiated events	ying njury										
EXB	resulting in death) La	ast	Due to	(or as a conse	quence of):							
edical			_ d									
ē	15.55111.5					~ ~~		-				
anya anya	IF FEMALE: 23b. Was decedent p		23c. If yes, ou	tcome of preg		3 □Ectopic pregnanc	cy			- 1	23d. Date of del	•
nysician/M	in the past 12 m		4☐Preg	nant at time of		5 ☐ Other (specify)					Month	Day Year
	9 Unknown								40 011			
2	Part II. Other signific	ant conditions o	contributing to c	eath but not re	sulting in the	underlying cause g	iven in Part	1.				the cause of death?
2										Yes 2	□ No 3□Pr	obably 4 ©Unknown
piered									24a. Wa auto	opsv	prior to	itopsy findings available completion of cause of
5									pen 1 ☐ Yes	formed? 2⊠ No	death?	2 🗆 No
De C	25. Was case referre	d to medical				To		e of Death	(Check only	one)		
2	1 ☐ Yes 2 🔀 N	lo		Inpatient 2		ient 3L DUA					6 ☐Other (Spe	cify)
Certification:	27. Manner of Death 1 XNatural	5 Pending		of Injury oth, Day Year)	28b. Time Injur	y Wo	ork?		28d. Describe	how infu	iry occurred	
3	2 ☐ Accident 3 ☐ Suicide	investigatio			4		]Yes 2 □		2011	<b>10</b> 1		
i	4 Homicide	determined	200. Place	e of Infury - At ling, etc. <i>(Sp</i> ec		street, factory, office	•		28t. Location City or To	(Street a own, Stat	nd Number or Hi e)	ural Route Number,
		<del>X</del>	<u>                                     </u>	1								
edicai	29a. Certifier (Check only 2 one)	Medical Exam	miner: On the b	e best of my ki pasis of examinated.	nation and/o	eath occurred at the investigation, in my	opinion, de	nd place, ath occurr	and due to the ed at the time	e cause(s ), date an	d place, and due	to the cause(s)
Med	29b. Signature and ti	itle of pertifier	ung mai	/		29c. Licer	nse number			29d. Da	ate signed (Mont	h. Day, Year)
	> 7	leva BA	15,0	and let	16	1 -100	00					
	30. Name and address	Convies	completed as:	sa of dansh (14	/// /	D4280	UÜ			FEBI	RUARY 3,	2004
						ALTH CARE	SYSTE	EM, P	ERRY P	OINT	, MD 21	902
e	31. Date filed (Month		32. 1	Registrar's Sig	nature			, -				
ar		0 5 2004		and H		R)						
	ELD	H 3 7004	A TOWN	Street Sept		- Challe						

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) Month 02 Helen Mary Gostomski 01 2004 3:25 AM 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Lorien of Bel Air Harford 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (Stete or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours 1 ☐ M 2 🛛 F Yrs 218-34-1522 91 08/10/1912 Maryland Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2√∑ No MD. Harford Fallston 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21047 600 Mountain Road U.S.A. 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Cook John Carroll Convent 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vincent Gostomski Mary Kowalsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 908 Lakeside Terrace - Bel Air, MD 21014 Frank E. Gostomski (brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/05/04 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gdns. Fallston, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, MD 21087 00 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Several Ravs Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 202 No

Physician /Medical Examiner

**Physician** 

/Medical

Directo

Funeral

ģ

Completed

Examiner

**Funeral** 

Director

the Maryland

Maryland 21215-0020

altimore,

SKill

ostom

Examine sician and burial-transit physician a sthe burial Physician/Medical attending a þ Completed page 2 s After this certificate has To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i Be Certification: To

The law raquires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Dey Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

e of death (Item 23e) (Type, Print)

26. Place of Death (Check only one)

1 ☐ Yes 2 ☑ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

25. Was case referred to medical examiner?

30. Name and address of person who

31. Dete filed (Month Bay (Yes) 2004

1 Yes 2 No

27. Menper of Death

Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 T Homicide

29c. License number

29d. Date signed (Month, Dev. Year)

State Registrar

Medical

			1 - For State Registrar	State of Marylar	nd / Depa		t of H	ealth a				200	. 0	326
O.	Physic	ian	1. Decedent's Name (First, Middle, Last,							2. Date of Dea Month		Year	3. Time	e of Death
	/Medi	cal	Mary Virgina Geio  4a. Facility Name (If not institution, give	<u>-                                      </u>		45 025 7	-	1	(5 "	January		2004	5:00	P M
4	Exami	ner	Maria Health Care				timo	Location o	of Death			unty of Deeth		
1	Funeral		5. Social Security Number 6. Sec	x 7. Age (In vrs	last birthday)	If Under	1 Year	If Under 2		8. Date of Birth		Baltím 9. Birth		te or Foreign
	Director		220-62-1993 15 Usual Residence of Decedent	M 20 F 88	Yrs.	Months	Days	Hours	Min.	(Month, Day Feb. 2,	1915	Col	NJ	
	Marylan -f show fied at	tor	10a. State 10b. County  MD Baltin		y,Town or Lo Balti									City Limits
	th the	Director	10e. Street and Number			10f. Zip	Code			1	0g. Citizen	of What Cou	untry?	
	ath wi	a	6401 N. Charles S	St.			212	12				USA		
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If the alth and Mental Hygiene. If the marked other than "netural", or items 23s or 28e-f show other treumatic svent, If a Medical Examine I. and be notified at	by Funeral	11. Marital Status  XX Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes XM No If Yes, Give Year or Dates:	If	Vas Decede f Yes, speci Yes 2			jin? (Sp , Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White		,
21215-0036	ithin 72 ha	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give i life. E	lent's Usual kind of work OO NOT use	Occupa k done du e retired)	tion uring most	of work	ing	16b. Kind o	of Business/Ir	ndustry	
7	led wi	Con		5+		Teach						nial s	chool	
and	d be fi	Be	17. Father's Name (First, Middle, Last) Frank Geiger							e (First, Middle, M		name)		
Maryland	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (Ty)	pe. Print)	19h Mailin	a Address /	(Street a)			th Oller		Ct 7:	- 0 - 1 - 1	<u></u>
N N	nd 2 salth ar alth ar 27 is rrtreu		Bernice Feilinger		6401	N. C	harl	es St	. , I	Baltimor	e, MD	wn, Stare, 21 21212	) Code)	
altimore,	as 1 a of Hea litern rotha		20a. Method of Disposition		lace of Disposemetery, crem	sition (Name	e of					on - City or T		
Ĕ	Pag ment ant: il ury o		1		lege o				1/31/	/04 в	altim	ore, N	1D	
Ball	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		21. Signature of Funeral Septiment Obense	in Konakr	Mi	Name and tchel Ol Yo	1 – W i	edefé	10 1	Funeral timore,	Home MD 21	212		
	dearn certificate be executed  e attending physician and tor use as the burial-transit	lical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a	uence of):	OR,	9	F	RI	UIR	E		Onset and	d Death
O. Box 68	deam certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes X♥No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 🗆	Ectopic prec						Date of delive	ery Day	Year
ecords, P	ine law requires mat me te has been signed by the age 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but not resu	Ilting in the und	derlying cau	use given	in Part I.		23e. Did tob		ontribute to th		
ក្ល	s beer	lete								24a. Was an				
	G 77	e Completed								autopsy perform 1 Yes	ed?	b. Were auto prior to con death? 1 \( \text{Yes}		cause of
5	this certific	0 8	25. Was case referred to medical examiner? 1 ☐ Yes 2777No	ospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpotiont	2 004				(Check only one			-	
on or	th. : After this funeral di	tion: T	27. Manner of Death  1XXIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Work?	ıt	2	ne 5 Resider 28d. Describe how	rce 6 ∐C vinjury occ	other (Specifi curred	)	
DIVISION	within 24 hours after death. To the Funerel Director: After t completely filled in by the funera	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, stree					28f. Location (Stre City or Town,	eet and Nur State)	mber or Rura	l Route Nu	mber,
	n 24 hour n 24 hour ne Funera	edical (	29a. Certifier X Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death of ion and/or inve	occurred at estigation, in	the time,	date and lion, death	place, a occurre	and due to the cau	ise(s) and r e and place	manner as st e, and due to	ated. the cause	(s)
‡ 0 1	withir comp	ž	29b. Signature and title of conflier	11/	11	29c) L	icense n	umber		29	d. Date gigr	ned (Month)	Day, Year)	
			1/1/	11	/	$\times$	D	0033	321	5	112	29/0	)4	
			30. Name and address of person who or								1/1	11		
	Sta	0	Shirley Thompson-F	Richards, MD, 32. Registrar's Signati	7401 O	sler	Driv	e, To	owso	n, MD 21	204			
	Registra		FFR 0.5.20	Pi		and a	1							

Phys /Me Exar Funer

Direct permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be multilised at

4:4SPM

1-30.04

Baltimore, Maryland 21215-0036

GARTSIDE, RONALD

Physicia /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - Stata Registrar			Cei	tificate of	Death	• 1	Reg. No.	UUM	0326			
an cal	Decedent's Name (First, Midd.	Ronal	d Jac	k	Gartsi	đe	2. Date of Dea Month Januar	Day	Year 2004	3. Time of Death 4:45 P			
	4a. Facility Name (If not institution Gilchrist Nur				4b. City, Town,	or Location of Dea	ath	4c. Cou	unty of Deat Balti	more Co.			
	5. Social Security Number 215–24–1186		7. Age (In yrs. )	last birthday) Yrs.	If Under 1 Yea Months Day:	r If Under 24 Hr		v. Year)	9. Birti Co	nplace (State or Fore untry) ryland			
}-	Usual Residence of Decedent  10a. State 10b. County	,	10c. City	y, Town or Lo	cation					10d. Inside City Lim			
Director	Maryland  10e. Street and Number	Baltimore			10f. Zip Code		Essex	10g. Citizen	of What Co				
a Di	410 North Wo	odward Dri	ve			212	221	Ur	nited	States			
y Funeral	11. Marital Status 1 ☐ Never Married 2☑ Mar	ned 1 ∑ Yes	2 🗆 No			ıban, Məxican, Pue	(Specify Yes or No erto Rican, etc.)		Race - Ame Black, White ecify:	rican Indian, a, etc. White			
eted by	3 Widowed 4 Divorced  15. Deceder  (Specify only higher	Year or Da nt's Education est grade completed)	ates: 1947-	16a. Dece	tent's Usual Occ kind of work don DO NOT use retii	e during most of w	orking	16b. Kind o	of Business/				
Completed	Elementary/Secondary (0-12) 6 Years 17. Father's Name (First, Middle	College (1	-4or 5+)		lillwrig	ht	ame (First, Middle,			dustry			
o Be	Milton Garts					-	la Schind						
2	19a. Informant's Name/Relation Mrs. June R. G	ship (Type, Print)	ife)		3		Rural Route Numbe Drive E			Tip Code) and 21221			
To Be Completed by Funeral Director	20a. Method of Disposition 1 □ Burial 2 私 Cremation	3 Removal from	20b. P	emetery, crei	sition (Name of natory or other p	(ace) Corp. 2	Date ///2004		ion - City or	Town, State			
	*4 □ Donation 5 □ Other ( 21. Signature of Funeral Service			22 I		ress of Facility k Funeral	l Home of	Dunda	alk, I	inc.			
dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Highry that initiated events resulting in death) Last	b	or as a conseq	uence of):									
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	come of pregna pirth 2   Feta ant at time of d	death 3	Ectopic pregnar Other (specify)			23d	Date of del	ivery Day Year			
þ	Part II. Other significant condit	ions contributing to de	eath but not res	ulting in the u	nderlying cause	given in Part I.	23e. Did t			the cause of death'			
Completed							24a. Was autop perfo 1 □ Yes		prior to death?	itopsy findings available completion of cause			
To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital:		ER/Outpatie	IT JU DOA	Other: 4 Nursing	Home 5 Resident	dence 6 K	ther (Spe	city) Hospi			
Certification:	1 Natural 5 ☐ Pend 2 ☐ Accident inves 3 ☐ Suicide 6 ☐ Could	ing (Moniting at Inc.) I not be 28e. Place	th, Day Year)	Injury ome, farm, st	W	□Yes 2□No		Street and N		ıral Route Number,			
Medical C		ing Physician: To the Il Examiner: On the b and man		ation and/or in	vestigation, in m	y opinion, death oc	curred at the time,	date and pla	ice, and due	to the cause(s)			
Me	29b. Signature and title of partif	they al	y, u	no	29c. Lice D 2	nse number		JAU	igned (Mont	h, Day, Year)			
	30. Name and address of perso								Date signed (Month, Day, Year)  AUSAY7 30, 200 8  2020				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar		artmen rtificate				Re	g. No 2 (	104	03269
ı	Physici /Medio		1. Decedent's Name (First, Middle, Las  WANDA Go	dwin						Date of Death Month	Day	O4	3. Time of Death
	Examir Funeral Director	ner	4a. Facility Name (If not institution, give CatoN5 Villo 5. Social Security Number 2/4-80-3813	e Commons	last birthday) Yrs.	4b. City,  If Under  Months	Car	ocation of D ONSV If Under 24 Hours	Hrs. 8.	Date of Birth (Month, Day,	Year)	9. Birthc	nouse, County place (State or Foreign try) MD
	9	tor	Usuel Residence of Decedent  10a. State 10b. County  MD W		ty, Town or Lo	_	-e			<u> </u>	7700	1	0d. Inside City Limits 1 ☐ Yes 2 ☑ 100
	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f show Ite Medical Exembranishe mailled at	Funeral Director	10e. Street and Number  726 N. Hiltor  11. Marital Status	12. Was Decedent Ever in U	l.S. 13.	10f. Zip	21	229	? (Specify	/ Yes or No- an, etc.)	14. Ra	15 A	ean Indian,
215-0036	2 hours after atural', or ita	ğ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Ed	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	16a Dece	1 ☐ Yes 2	2 DNo	Specify:			Spec.		1964
7	filed within 7 Hygiene. other than "n ent, the Medi	e Completed	(Specify only highest grad Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life.		IVSIL			irst, Middle, M			Duty
Maryland	Pages 1 and 2 should Inent of Health and Men ant: if itam 27 is marke ury or other traumatic.	To Be	19a. Informant's Name/Relationship (7	HIN JR.	19b. Mailir	ng Address	(Street an		^	te Number,		n, State, Zip	·
_			BeHy J. Scott 20a. Method of Disposition 1 Weurial 2 Cremation 3 C 4 Operation 5 Other (Specify	20b. I	910 Place of Dispo cometery, crei	natory or o	ther place)	Lunt De z	Po Date	2	0c. Location	- City or To	40 21279 own, State
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licen		22	2. Name an	d Address	of Facility	. Clo ssiet	se Fu St.	neval Balti		TCR. P. A. MD 21201
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the dearne cause on each line.  a. Due to (or as a consec	AT	b S	e of dying,	such as ca	rdiac or re	spiratory arres	st,		Approximate Interval Between Onset and Death
68760,		icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispass or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect d.									
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	aldeath 3	Ectopic pro				210720000000000000000000000000000000000		ate of delive	ory Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions of	ontributing to death but not res	-	nderlying ca	ause given	in Part I.	_		acco use cor ; 2 □ No	ntribute to th 3 ☐ Prob	ne cause of death?
al Records,	sician: The law ri certificate has be lirector, page 2 shi	Completed by							_		ed? No	Were auto prior to con death? 1 \( \subseteq Yes	psy findings available apletion of cause of
on of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tion; To Be	25. Was case referred to medical examiner?  1  Yes	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		8c. Injury a Work?	4 Sursi	ng Home 28d	heck only one 5 Residen Describe how	ice 6 □Ot		/)
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	eet, factory	, office		28f.	Location (Stre City or Town,		ber or Rura	l Route Number,
	tha Hospi hin 24 hou tha Funar npletely fill	Medical	(Check only 2 Medicel Examone)	rsician: To the best of my known iner: On the basis of examination and manner stated.	owledge, death ation and/or in	vestigation,	at the time in my opir License r	nion, death	olace, and occurred	it the time, dat	use(s) and me and place	, and due to	the cause(s)
	Twiting To		29b. Signature and title of certifler  WHELEVAL  30. Name and address of person who of	M . D	n 23a) (Type,	D	005	545		JA	TUVAR	4 4	2604
	Sta Regist	ate rar	NANA CEASAR; 31. Date filed (Month, Day, Year) FFR 0.5 2004	S D I N - E	1 11 0	STR	ET 7	181	427	MORE	- MD	21	201

			State of Maryland / Departm  1 - For Amend Item 28d per ME., G827, 01/27/04dhe ertific	ent of Health and Neate of Death	Mental Hygid	ene g. No. 2004	03270
	Physici		1. Decedent's Name (First, Middle, Last) Christopher E. Goldbeck		2. Date of Death Month JANUARY		3. Time of Death
•	/Medi Examir		ST- JOSEPH MEDICAL CENTER	City, Town, or Location of Death	<i>y</i>	4c. County of Death	n
	Funeral Director		213-03-6645   ▼ M 2□F   85 Yrs. Moni	ths Days Hours Min.	8. Date of Birth 08/07/1	9. Birth	nplace (Stete or Foreign unity) aryland
	Maryland a-f show	tor	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   MD   N/A   Baltimore				10d. Inside City Limits 1   Yes 2  No
	h with the 23a or 28	Funeral Director	10e. Street and Number 2211 Kentucky Avenue	Zip Code 21213		g. Citizen of What Co USA	untry?
036	be filed within 72 hours after death with the Maryland hal Hygiene. do other then "natural", or itema 23e or 28e-f show event, the Medical Exam are must be notified at	by	1 Never Married \$ Narried 1 Yes 2 No	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerlo is 25(No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
Baltimore, Maryland 21215-0036	e filed within 72 ha il Hygiene. other then "natu vent, ins wedical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Carpente	f work doné during most of work IT use retired)	ing 16	Baltimore	
/land	a a a a	To Be (	17. Father's Name (First, Middle, Last) Christopher E. Goldbeck		e (First, Middle, Ma ne R. Sch		
, Mar	as 1 and 2 should of Health and Men litem 27 Is marke r other traumatic		Victoria V. Goldbeck Wife 2211 Ke	ress (Street and Number or Run ntucky Avenue l			
more	permit. Pages 1 Department of H Important: If iter any injury or oth		20a. Method of Disposition  1 \ Burial 2 \ Cremation 3 \ Removal from State  4 \ Donation 5 \ Other (Seqcify)	or other place)		oc. Location - City or T altimore N	
Balt	permit. Departi Import any inj		ale Funera Maryland	1 Home 21237			
	Physician		23a. Pent 1. Enter the disease, or complications that caused the death. Do not enter the rishock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		or respiratory arrest	t,	Approximate Interval Between Onset and Death 2 DAYS
8760,	Medical Examiner  bhysicien and british transit sthe british transit	dicai Examiner	resulting in death)  Sequentially list conditions, if arry, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  CARDID—REST IRAT Conditions.  Due to (or as a consequence of):  Due to (or as a consequence of):	TORY ARRETT			
P.O. Box 68	ne death certif the attending hed for use as	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetel death 3   Ectopic 1   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetel death 3   Ectopic 1   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetel death 3   Ectopic 1   23c. If yes, outcome of pregnancy 1   23c	c pregnancy (specify)	ED BY MEDICAL EXA	M ER 23d. Date of deliv Month	rery Day Year
as, r	uires that the signed by the detaction	d by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying RIGHT HIP FRACTURE	ng cause given in Part I.	23e. Did tobad	SOO GOO CONTINUETO TO	the cause of death?
l Recor	The law requires that ate has been signed b page 2 should be deta	Completed	CARDIOMYOPATHY AORTIC STENOSIS		24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Division of Vital Records,	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: Afer this certificate ha completely filled in by the funeral director, page	Certification: To Be C	25. Was case referred to medical examiner?  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Yeer) Injury 28b. Time of Injury (Month, Day Yeer)  28b. Place of Injury - At home, farm, street, face building, etc. (Specify)	DOA Other: 4 Nursing Hol 28c. Injury at Work? 1 Yes 2 No	me 5 Residence 28d. Describe how 28f. Location (Street City or Town, E	te 6 Other (Specinipury occurred Subsection)	ject Fell
_	To the Hospital within 24 hours a To the Funeral C completely filled it	Medical Co	29a. Certifier (Check only one)    Certifying Physician: To the best of my knowledge, death occurr on the basis of examination and/or investigat and manner stated.	red at the time, date and place, a ion, in my opinion, death occurre	IJI Kentu and due to the caus ed at the time, date	se(s) and manner as s	stated. o the cause(s)
	To the To the comp	Me	· Dance	29c. License number D 30263	29d.	Date signed (Month,	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  FRANCIS KHOO MD 7601 OSLER D  31. Date filed (Month, Day, Year)  33. Pegistrar's Signature	RIVE, TOWSO	N, NO	21204	
	Sta Registr	-	31. Date filed (Month, Day, Year)  JAN 2 8 2004	*			

			1 - State Registrar	State of M	laryland ,		artment of Hartificate of L		nd Mental Hy	giene Reg. No. 20	04	032	71
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last William Gills	)					2. Date of De Month Januar	Day	rear 04	3. Time of D	
	Examin		4a. Fecility Name (If not institution, give Springfield Hospi		")	Tie	4b. City, Town, or Sykesv		Death	4c. County o			
6	Funeral Director		214-/6-41/5	7. A	ge (In yrs. last 39	birthday) Yrs.	If Under 1 Year Months Days		Min. Apr 8,	h		ce (Stete or i	Foreign unk
	e Maryland Sa-f show	Director	Usual Residence of Decedent	1	10c. City, T		cation /ille				100	1. Inside City 1 ☐ Yes 2	
	ath with the 23e or 2	ral Dire	10e. Street and Number 6655 Sykesville R					21784		10g. Citizen of Wh			
036	hours after death with the Maryland tural', or Items 23a or 28a-1 show at Examiner must be notified at	by Funeral	11. Marital Status  12 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?		Vas Decedent of His f Yes, specify Cubar I ☐ Yes 2X No	spanic Origin n, Mexican, F Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race Black, Specify:	Americar White, et bla	C.	
9500-61212	within 72 ane. than "nai	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) unk un	completed) College (1-4or		(Give	lent's Usual Dccupa kind of work done di 20 NOT use retired)	urina most o	working unk	16b. Kind of Busi	ness/Indu	stry	unk
yland	should be filed nd Mental Hygid marked other imatic avent, II	To Be C	17. Father's Name (First, Middle, Last)				unk	18. Mother's	Name (First, Middle,	Maiden Sumame,			unk
Mar	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic a one.		19a. Informant's Name/Relationship (Ty Carroll Hospital 20a. Method of Disposition	Center	20b. Place	200 N		Avenue	or Rural Route Numbe Westminst Date		21157	7	
saitimore,	ermit. Page Separtment o nportant: If ny injury or thee.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☒ Other (Specify)  21. Signature of Funeral Service Licens Ronald S.	in stat	' i	22 S t	Name and Address	s of Facility	ard 655 W.	Baltimo	ce St	reet	
V (10 m)	Cate be executed /Medical Examiner the purial-transit	i Examiner	23a. Ran1. Enter the disease, or comples once, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	d the death. Dine.	ce of):	Itimore, or the mode of dying		1201 rdiac or respiratory ar	rest,	l Ir	pproximate interval Betwe Inset and De	
.o. Box 68/60	death certifi e attending d for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown		e of pregnancy 2 Defeal dea at time of death	ath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month		ау Үег	ar
ras, r	The law requires that the tee has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions con	atributing to death t	but not resulting	g in the un	derlying cause giver	n in Part I.		bacco use contrib es 2□No 3	ute to the	<b>\</b> /	
	2 8 8	Completed	CHRONIC	REH	AL	F	AILLIF	RE_	24a. Was a autop perfor 1 Yes	med/? dea	ith? 🚬	y findings availation of cause	aliable ise of
vision or vital	ng Phy fter this meral d	Certification; To Be	27. Manner of Jeath  Accident investigation  3 Suicide 6 Could not be	28a. Date of Inju	ay Year) 28t	Outpatient  Time of Injury	3 DOA Other 28c. Injury Work? M 1 7			ence 6 Other			
2	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	al Certif	4 Homicide determined  29a. Certifier Certifying Physics	building, et	tc. (Specify) of my knowled	lge, death	et, factory, office	a. date and p	City or Tow	ause(s) and mann	er as state	ad .	or,
	To the Ma within 24 t To the Fu completely	Medical	(Check only 2 Medical Examinate)  29b. Signature and title of certifier	ner: On the basis of and manner st	of examination :	and/or inv	estigation, in my opi	nion, death o	occurred at the time, d	late and place, and	d due to th	e cause(s)	
- 17	Sta Registr		30. Name and address of person who co	BUT	death (İtem 23a	D	Print) 20 Suite	10:	PRODUCE 2, Our	igs n	113	MD 211	(7

DHMH 17 Rev 1/2001

ORIGINAL

			_ For	i lease i	State of M							-	ene o o o	1 00000
			1 - State Registrar							Death			J. No.	4 032/2
	Physic	ian		e (First, Middle, Last)								Date of Death Month	Day Yeer	3. Time of Death
	/Medi	cal	WAYMAN	HOLLEY								bryaru	2, 2004	1 9:00 A M
	Exami	ner	C	f not institution, give s	street and number	115	4 00	Q		r Location of De	0	1	4c. County of De	eth
	Funeral		5. Social Security N	umber 6. Sex	7. A		move last birthday	y) If Unde	er 1 Year	If Under 24 F	Irs. 8.	Date of Birth		irthplace (State or Foreign Country)
L <sub>2</sub>			212 14	1010	M 2□F	86	Yrs.	Months	Days	Hours M	fin. A	Date of Birth Month, Dey, Y PR • 16	,1917 GI	EORGIA
) Ju	and		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or I	Location						10d. Inside City Limits
7	Maryl	to	MD.	BALTÍMOR	E	1	LTIM							1 Yes X No
3	death with the Maryland ms 23s or 28e-f show	by Funeral Director	10e. Street and Nur	nber			<del></del>	10f. Z	ip Code			100	. Citizen of What C	Country?
7	ath wil	alD	7041 TO	BY DRIVE					2120	9		U	.S. OF A	Α.
==	er de	une	11. Maritat Status		12. Was Decedent Armed Forces	? 10 <i>1</i>	.S. 13	I. Was Dece If Yes, sp	edent of H	lispanic Origin? an, Mexican, Pu	(Specify lerto Rica	Yes or No- n, etc.)	14. Race - Arr Black, Wh	
386	urs aft	by F	1 ☐ Never Marri	ed 2 Married 4 Divorced	1	<sup>№</sup> 194		1 🗆 Yes	2 <b>X</b> No	Specify:			Specify: BI	LACK
35	72 hours netural', dical Eva	ted	/Cone	15. Decedent's Educ	cation		16a. Dec	edent's Usi	ual Occup	ation		16	b. Kind of Busines	
2 L	of Man	Completed	Elementary/Seco	ndary (0-12)	College (1-4or	5+)		ARTM:		during most of v	working			
25	e filed within al Hygiene. other then '	S	12TH 17. Father's Name		YEARS		DEP	AKIM.	EW.L		lama /Fin		JBLIC SC	CHOOLS
and	Mental I Merkad of atlc eve	To Be		HOLLEY	(DECEAS	ED)					,	•	,	ECEASED)
also Known as Holley, Wayman Maryland 21215-0036	2 should be and Menta le markad aumatic ev	-		ame/Relationship (Typ			19b. Mai	ling Addres	s (Street				iny or Town, State MARYLA	
	is 1 and 2 of Health a item 27 le		DEBORAH	HOLLEY	(DAUGHT	ER)	706	7 TOI	BY D	RIVE	BAL	FIMORE	E, MARYLA	ND21209
Strent Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Ie markad other than *netural', or Items 23a or 28e-1 ehow any injury or other traumatic event, tra Madical Exant actinual be tradited at ΩDGE.		20a. Method of Disp	oosition Cremation 3 Re	emoval from State	l c	lace of Disp	ematory or	other place	2/	10%		c. Location - City o	r Town, State LLS, MARYLAI
A T	permit. Pages Department of I Important: If its any injury or o		` 4 □Donation	5 Other (Specify)		GAR	-					•		
Bal	permi Depa Impo any ir		21. Signature of 10	neral Service License LEWIS	T. GWY	NN		CEWIS	S T	ss GWYNN	FUI	NERAL	HOME 21	215-6393
			23a. Part1. Enter th	ne disease, or complic rt failure. List only on	cations that cause	the death	n. Do not er	DI/ ]	PARK de of dyin	HEIGH	ITS I	AVENUE piratory arrest	BALTO	Approximate
	Physician		Immediate Cause ( disease or conditio	Finat	e cause on each i				ure					Onset and Death
	/Medical		resulting in death)	(°	Due to (or as			1 241	urc					Zueeks
	Examiner		Sequentially list con	nditions, b		er te,								:
_	ted nsit	Examiner	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or that initiated events	mediate rlying injury	Due to (or as	a consequ	uence of):							
·	execunand and latera	Exar	that initiated events resulting in death) L	ast	Due to (or as	a consequ	uence of):							
760,	res that the death certificate be executed igned by the attending physician and be detached for use as the buriat-transit	call		d	,									
89	ntifica ing ph s as th	Medi	IF FEMALE:	- 3 3										
Вох	ath ce	ian/I	23b. Was decedent in the past 12	pregnant	3c. If yes, outcome 1 Live birth	2 Fetel	death 3	□Ectopic p					23d. Date of de	livery Day Year
	the de	Physician/Med	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant a 9□Unknown	t time of de	eath 5	Other (s	pecify)				, month	ouy rou
σ.	The law requires that the death certifica tite has been signed by the attending phi vage 2 should be detached for use as th	y Ph	Part II. Other signifi	icant conditions conf	tributing to death b	out not resu	ulting in the	underlying	cause give	en in Part I.		23e. Did tobac	co use contribute t	o the cause of death?
rds	w requires been sign should be	Completed by	Chronic	- renal f	ailure							1 🗌 Yes	2 □ No 3 □ P	robably 4 Unknown
eco	law requ as been 2 shouk	plet	Perigher	al vascu	lar dis	ease	n.jdv					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
E B		Con	•								-   .	performe 1 □ Yes 2 □	d? death?	1
Vita	Physician: this certificatal director, I	Be	25. Was case referr examiner?	/	ospital:			_	0.4	26. Place of D				
to.	> 0 0	1: To	1 Yes 2 27. Manner of Death	NO	28a. Date of Inju	irv	ER/Outpatie 28b. Time (		and the same of	4   Nursing			e 6 Other (Spe	ecify)
ion	Attending or death.	atior	1 Matural 2 ☐ Accident	5 Pending investigation	(Month, Da	y Year)	Injury	M	28c. Injury Work	k? Yes 2 □ No			,,	
Division of Vital Records, P.O.	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj	ury - At ho	me, farm, si	treet, factor	y, office		28f. L	ocation (Stree	it and Number or R	ural Route Number,
Q	risal or ral Dir													
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai	29a. Certifier (Check only one)	1 Certifying Physi 2 Medicel Examin	er: On the basis o	r examınat	wledge, dea ion and/or in	th occurred nvestigation	at the time, in my op	ne, date and pla pinion, death oc	ce, and d	lue to the caus the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	o the	Med	29b. Signature and	title of certifier	and manner st	ated.		29	c. License	number		29d.	Date signed (Mon.	th, Dey. Year)
	\- = 0		Haller	1 Harti	nan N	(.)		4	126	5-001	0			
Δ	011			ess of person who cor	npleted cause of c	leath (Item		P 10		1			_	2,2004
	0		Kache	TI CO	nan M	. D.		Sinai	Ho	spital	of	- Ba	Himore	
	Sta Registr		31. Date filed (Mont	n, Day, Yeer) FFR <b>0</b> 5 20	32. Registr	ar's Signat	ture	9	100	W Y				
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death\_ HARRIS Day Year **Physician** 3 PEBRUARY 200 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Deeth Examiner MANDALISTOWN HOSPITAL SACTIMORE HWEST If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 10 M 20 F Days Hours 212.40.4654 Months Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? exham 21244 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced BIACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) injury or other traumatic svent, 17. Father's Name (First, Middle, Last) Witam 27 is marked others. 18. Mother's Name (First, Middle, Maiden Sumame, Be 2 40n 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lexham (7 mo 21244 Harri 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
any injury or ot
once. 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State 2-10-04 \* 4 ☐ Donation 5 ☐ Other (Specify) Altimore, mount Crematory 22. Name and Address of Facility Vaugus C Greene Forent Selvices 21. Signature of Funeral Service Licensee Rd C. berty Randalls Town, MD 21133 Kelne 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) the 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autonsy performed? certificate 20 No 1 Yes 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

32. Regis ar's Signature

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THWEST HOSP

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			ricase i	State of Maryland / [	Denartment of H		_		
			1 - For State Registrar	otate of marytana / 1	Certificate of		Reg.	. / IIII la	03274
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medic		Elizaheth (	U. Hooper			Month	Day Year	4:008 M
No.	Examin	- 4	4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, o	Location of Death		4c. County of Deeth	
			Levindale Hebrew			MOIC If Under 24 Hrs.	0. O ( D) db	o Birth	
	Funeral		5. Social Security Number 6. Sex	M 2 F 7. Age 7th yrs. last bit	Months Dave	Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birth	place (State or Foreign Intry)
	Director		Usuel Residence of Decedent	//			/d - // -	~7	THE
	how		10a. State 10b. County	10c. City, Tow	m or Location				10d. Inside City Limits
	Ba-f s	cto	MO Carroll	West,	Minster				1 Yes 2 No
	with th	Die	10e. Street and Number	2.1	10f. Zip Code	-0	10g.	Citizen of What Cou	intry?
	ns 23	Funeral Director	345 Pleasanto	N Kd 12. Was Decedent Ever in U.S.	3. Was Decedent of H		cify Yes or No-	USA 14. Race - Amer	ican Indian,
(0	r Item	듄	1 □ Never Married 2 Ø Married	Armed Forces? 1 ☐ Yes 2 ØNo	13. Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, White	, etc.
03	ral', o	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify: B	ACK
5-0	illed within 72 hours after deeth with the Maryland Hygiene kther than "natural", or Items 23a or 28a-f show kther than "natural", or Items 23a or 288-f show int, the Medical Exaciliser must be coeffied at	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a	. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of working	16b	. Kind of Business/li	ndustry
12	within ene. than	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	NU VS			Haso:	Va 8
<b>d</b> 2	e filed within al Hygiene. I other than vent, tre Me	ပိ	17. Father's Name (First, Middle, Last)	ayes	7007		(First, Middle, Maid	len Sumame)	70-1
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Maryland 21215-0036	2 should and Men is marke sumatic		19a Informant's Name/Relationship (Typ	00, Print), 19b	. Mailing Address (Street	and Number or Rura	Route Number, Cit		p Code)
	and 2 lealth m 27 i		KalpH G. Hoop	er/Husband 3	45 PROSON		Vestminste		157
ore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition  1 Ø Burial 2 ☐ Cremation 3 ☐ Re	comete	f Disposition (Name of ry, crematory or other place	(8)	ate 20c	Location - City or T	own, State
Baltimore,			'4 Donation 5 Other (Specify)		nsuille VA	2-5-	04 (1	Duns Ville	Se (vices
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service License	2.6	22. Name and Addre	- 1 0	)	IND 71133	
			23a. Part1. Enter the disease, or complication shock, or fleart failure. List only on	cations that caused the death. Do	not enter the mode of dyir	7		1140 01132	Approximate
1	Physician	9 4	Immediate Cause (Final disease or condition	ATHERD SCH	GROTIC CA	RDIOVAS	LULAR	D136A50	Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence					
В	Examiner		Sequentially list conditions.						
	ed sit	ine	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a nonsequence	of)·				
	be executed ician and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence	of):				
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89	tifficat og phy as th								185117-5
Вох	ith cer tendir r use	Physician/Medi	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	n 3 ⊟Ectopic pregnancy	,		23d. Date of deliv	very Day Year
-	the at	sici	in the past 12 monuts? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)			Mortu	Day 19a1
P.O.	t th		Part II. Other significant conditions con	tributing to death but not resulting i	n the underlying cause giv	en in Part I	23e. Did tobaco	to use contribute to	the cause of death?
of Vital Records,	signed d be del	Completed by	OBSTRUCTIVE	SLEEP AT	NOBA		1 🗆 Yes	2 No 3 □ Pro	bably 4 □Unknown
COL	w requir been si should	lete	MORBIN DI	ᢖ <i>ᢎ</i> ᢌᡣ᠊ᡇ.			24a. Was an	24b. Were aut	opsy findings available
Re	The lav	ошо	7	<u></u>			autopsy performed	?_ death?	empletion of cause of
ital		4	25. Was case referred to medical			26. Place of Death		140 1 163	24110
<b>&gt;</b>	80 U TO	To B	examiner? 1 Yes 2 No	ospital: 1   Inpatient 2   ER/O	utpatient 3 DOA Oth	er: Nursing Hon	ne 5 🗆 Residence	6 ☐Other (Spec	fy)
0	ttending Phy death. :tor: After thi the funeral or		27. Manner of Death  Natural 5 Pending		Time of 28c, Injur	k?	8d. Describe how is	njury occurred	
sio	Attending It death. ector: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	One Diese of leiter. At home 6		Yes 2 □ No	Of Languing (Comme	and Number or Co	I Pouto Alumbor
Division	l or Attencafter death Director:	Certification;	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	-	City or Town, Si	and Number or Rui ate)	al Houte Number,
<u> </u>	Hospitel of Pours at Funerel Distriction of Funerel Distriction of Filled in the Pours at 1985 and 198		29a. Certifier Certifying Phys	ician: To the best of my knowledge	e, death occurred at the tir	ne, date and place, a	nd due to the cause	e(s) and manner as	stated.
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	To the within 2 To the complei	ž	29b. Signature and title of certifier	~/ .	29c. Licens		29d.	Date signed (Month	Day, Year)
,	4		Agreem	Valenani.		2595		1/31/01	1
	* )		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)	HEICH)	3 AYE	BALMI	W221208
170	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra Signature		.,, -, -,	, ,		
	Pogist		annen O F	- 2004	2 8 10	7			

ert	Lee H	111	For State	State of Maryland / I	Departmer Certificat			ind Me		iene g. No. 2 (	004	03275
			Registrar     Decedent's Name (First, Middle, Last	")	Cortinoat	011	Journ		2. Date of Deat		0 0 7	3. Time of Death
	Physicia	an							Month	Day	Year	1815 p <sup>M</sup>
	/Medic		Robert 4a. Fecility Name (If not institution, give	Lee Hill	4h. City	Town, or	Location o		Februar	-	y of Death	1913 D
	Examin	er	21595 America S				gton			St.	Mary	's
	Funeral		5. Social Security Number 6. Se		rthday) If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birth			place (State or Foreign
We.	Funeral Director			XM 2□F 55	Yrs. Months	Days	Hours	Min.	(Month, Day, NOV . 07	1948	Cour	NC NC
	ס		Usual Residence of Decedent									
	thow	_	10a. State 10b. County	10c. City, Tow		inat	on Pa	nk				0d. Inside City Limits 1 ☐ Yes 2X☐ No
	Ba-1 s	cto	Maryland St. Mar	·y·s			OII Fa	IIK		0	14/5-1-0-1-	
	72 hours after death with the Maryland Fratural; or Itams 23a or 28a-f show dical Examinant to mulified at	Director	10e. Street and Number		10t. Zi	Code	೧೯೯೦		'	0g. Citizen of	USA	ury r
	ath v		21595 America St	12. Was Decedent Ever in U.S.	12 Was Dags		0653	nin? (Snec	ofy Vac or No.	14 Ba	ce - Americ	can Indian
	er de Itam	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?  1 Yes 21 No	If Yes, spe	city Cuba	n, Mexican	, Puerto R	offy Yes or No- lican, etc.)	Bla	ck, White,	etc.
36	Irs aff	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	2 💢 No	Specify:			Specia	<sub>fy:</sub> Bla	ICK
9	2 hou		15. Decedent's Ed		. Decedent's Usu			t of workin		16b. Kind of E	Business/In	dustry
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<u>yla</u>		2	Robert Whi				Nor			bell		
Maryland 21215-0036	and and is m		19a. Informant's Name/Relationship (7		o. Mailing Addres 21595 All							
	f Health item 27 other tra		Brenda Brown Hill		of Disposition (Na					20c. Location		
Ore	of of		20a. Method of Disposition 1 → Burial 2 → Cremation 3 →	Removal from State cemete	ry, crematory or	other plac		eb.			-	
Baltimore,	t. Pa tmen tant: njury		*4 Donation 5 □ Other (Specify		reen Cen			2004		Vew Bor		7
Bal	permit. Pag Department Important: I sny injury o		21. Signature of Funeral Service Licen	401.	.   )			51				ome, P.A.
	e)		23a. Part1/Enter the disease, or comp	plications that caused the death. Do	not enter the mo	MOUN de of dvin	Call g. such as	cardiac or	Pasader respiratory arr	na, MD est	2112	Approximate
			shock, or heart failure. List only of timmediate Cause (Final									Interval Between Onset and Death
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oʻ	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a consequence	of):							
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68	rtifica ng ph as th	Med	IC COMMIC.									
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	n 3 ⊟Ectopic p	regnancy					ate of delive	ery Day Year
	ne dea the att hed fo	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death 9☐Unknown	5 Other (s	pecify)					VIIII	Juy 102
P.O	that the di ed by the detached	Physician/Me	9 ☐ Unknown  Part II. Other significant conditions co	- tehuting to death but got cogniting	in the underlying	001100 0114	on in Part I		23e Did to	hacco use cor	stribute to t	he cause of death?
S,	res tha signed be de	þ	Part II. Other significant conditions of	SHIRD LING TO COME IT DUT NOT TO SURING	in the bilderlying	cause givi	en in it contra	•		es 2 No	3 ☐ Prot	a .
Records,	w require been si	Completed							-		Ware auto	opsy findings available
3ec	e law has t je 2 s	m ig							24a. Was a autops	sy	prior to co death?	impletion of cause of
	ician: The certificate his rector, page								12 Yes	2 No	Yes	2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	-		(Check only on		h (C	u at ggono
of	Phys this rai di	7.	1 X Yes 2 No 27. Manner of Death	28a. Date of Injury 28b.		28c. Injun	4 ∐ N⊔ γat		8d. Describe h			wat scene
	ding I h. After tuner	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	Worl	k? Yes 2□	No				ii)
Division	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, f	arm, street, facto	ry, office		2	8f. Location (S	treet and Num	ber or Rura	al Route Number,
ă	2 9 2 0	Certification:	4 Homicide	building, etc. (Specify)					City or Town	7, 3(a(e)		
6	ospital or A hours after uneral Dire ly filled in b			ysician: To the best of my knowledg								
×	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Examone)	niner: On the basis of examination a and manner stated.	nd/or investigatio	n, in my o	pinion, dea	in occurre				
	To t To t	Σ	29b. Signature and title of certifier	1 000	25	c. Licens				9d. Date sign: Februar		
	1		Taline	ale ffi			CME			COLUGI	-y 2 4	
	12		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print)	1 Pe	nn St	reet	. Baltir	nore. N	arvla	and 21201
			2915/hle/Pot	41					,			
		ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	And the							
	Regist	rar	EER 0 5 200	4 Liebers AF	ALL STREET							

			1 - For State Registrar	State of Ma	ryland /	-	artment of F		iene g. No. 20	n L	03:	276	
15	Physici	an	1. Decedent's Name (First, Middle, Last)	A .	1	1/-	ا ام		2. Date of Deat Month	n Day	/ear	3. Time of	110
1	/Medic	al	4a. Facility Name (If not institution, give s	street and number)	<u>_</u> ,-	44	Sh Cer	r ocation of Death	Februar	y 03 200		6:50	P <sup>M</sup>
	Examin	er	Hospice of the Ch					inthicum		Anne		de1	
ti.	Funeral Director		5. Social Security Number 188-20-5080 6. Sex		(In yrs. last i	yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 2	Year) 7 1927	9. Birthpla Country	ce (State or y) PA	Foreign
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation				100	d. Inside Cit	y Limits
	e Man	ctor	Maryland Anne Ar	undel			Pa	asadena				1 🗌 Yes	2 📈 No
	vith the	Director	10e. Street and Number				10f. Zip Code	0.1.1.0.0	10	g. Citizen of Wh		y?	
	ns 234	Funeral	1215 Hillside Roa	12. Was Decedent E	ever in U.S.	13.1	Was Decedent of H	21122 tispanic Origin? (Spi	ecify Yes or No-	14. Race -	JSA American	n Indian.	
21215-0036	within 72 hours after death with the Maryland ene. than 'natural', or Hems 23e or 28e-f show ta Madical Estanifer mail be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☑ Yes 2 ☑ N If Yes, Give Year or Dates:			f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	Rican, etc.)		white, et Whi	c.	
5-0	n 72 hours n *natural', solical Exa	Completed by	15. Decedent's Educ (Specify only highest grade	cation e completed)	16	(Give	dent's Usual Occup	during most of work	ng	6b. Kind of Busi	ness/Indu	stry	
121	d within giene. ir then ir e Me	Jumo	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. i	Se1f-Emp			der			
	othe	Be Co	17. Father's Name (First, Middle, Last)				Sell-Fill	18. Mother's Name	(First, Middle, N		uer		
Maryland	₫ a a a	To B	Richard He	Alberta	Rut		shop						
Mar	12 s h an 7 ls trau		19a. Informant's Name/Relationship (Ty) Blanch M. Hershber					and Number or Rura de Road, I					
	1 an Heal em 2 thar	3	20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place	Ť r	ate 2	Oc. Location - C			
OE I	0 0		1 ☐ Burial 2 反 Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1		matory Ir	. 1 50	09	Baltimor	e, M	aryla	nd
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	Aller	ss of Facility	Stalli	ngs Fune	ral 21122	Home,	P.A.			
	3.8		23a. Part. Enter the disease, or complishock, or heart failure. List only on	cations that caused ne cause on each lin	the quath. D						í Ir	Approximate	veen
	Physician	Ŷγ	Immediate Cause (Final disease or condition resulting in death)	M	etn.	itu	Liz L	ma C	ance	~		Onset and D	eath
	/Medical Examiner			Due to ( as a	consequenc	e of):		$\circ$					
Ų.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequenc	e of):							-
	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	CORCOGUORG	o of):							
8760,	sate be executed obysician and the burial-transif	alE		Due to (or as a	consequenc	e oi).							
9	<u>a</u> € €	edical	_ d										
О. Вох	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)	,		23d. Date of Month			ear
Vital Records, P.	juires that l n signed by ild be deta	by	Part II. Other significant conditions con	ntributing to death bu	it not resulting	in the u	nderlying cause give	en in Part I.		acco use contrib	ute to the	,	eath?
SCO	aw requir as been si 2 should I	plete							24a. Was ar	24b. We	re autops	y findings a	vailable
E Re		Completed							autopsy perform 1 Yes 2	ed/ dea	ath?	□ No	use of
Vita	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	lospital:			Oth	26. Place of Death		1	-1	1	
of	Phys r this ral di	7: To	1 Yes 2 No	1 ☐ Inpatier  28a. Date of Injur (Month, Day		. Time of	1 3 DOA	4   Nursing Ho	me 5 Resider 28d. Describe ho		(Specify	tospi	æ
ion	tending I Jeath. tor: After the funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury		k? Yes 2 □ No					
Division	or Attending after death. I Director: Afte d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	ry - At home, . (Specify)	farm, str	eet, factory, office		28f. Location (Str. City or Town,		or Rural F	Rou <i>te N</i> umb	er,
	Hospital (4 hours a) Funaral D		29a. Certifier 1 Certifying Phys	sician: To the best of	if my knowled	ne death	occurred at the tig	ne date and place	and due to the ca	use(s) and man	Or as state		
	To the Hospital or Attu within 24 hours after de To the Funaral Directo completely filled in by th	edical	(Check only 2 Medical Examir	ner: On the basis of and manner sta	examination a	and/or inv	estigation, in my of	pinion, death occurr	ed at the time, da	te and place, and	due to th	ne cause(s)	
)	To t To t	Σ	29b. Signature and title offcertifier	<b>O</b>			29c. License	flumber =	7 29	d. Date signed (	Month, Da	y, Year)	
	8		30- Name and a thress of person who co	mpleted cause of de	ath (tem 23a	) (Type,	Print) Marca	7. 11	RA Pa	padena	MV	7111	2)
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	700	Secret of	I) MIV	10	100	1 " "	· al	
	Registr	ar	FFR 0 5 20	104 2000	the of the	F	No. of Street						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 82, 2004 8:30 am **Physician** Hobbs June Elizabeth /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 35 Battersea Bridge Wav Timonium If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 2 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 XF West Virginia 233-28-9721 81 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 1 Yes 2 No Director Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21093 35 Battersea Bridge Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: Specify: White ð 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Holmes Clyde Quincy Thelma Mae Brown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Battersea Bridge Way Timonium, Md. 21093 Sharon Baker/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2-4-04 Towson, Md. Hilltop service Co. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEPATIC week /Medical Due to (or as a consequence of): **Examiner** OBSTRUCTION BILIARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed PRUBABLE attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ TERY 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 2.8 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification; After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Elizabel2 D51135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELIZABETH HALLORAN 5601 LOCH RAVEN BLVD, BALTIMORE MI 2004 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

				For State Registrar	State o	f Maryla	nd / Depa	artmeni rtificate	t of H	ealth a	and M	fental Hy	giene	2001	+ 03	278
		Physici	an	1. Decedent's Name (First, Middle,								2. Date of De. January	ath	200 <sup>Yeer</sup>	3. Time of	
		/Medio	cal	4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	of Death	Sandary		County of Dea		
		LXaiiii	161	Homewood at Cr	rumland F	arms			rede					Freder		
		Funeral Director		5. Social Security Number 229-07-0907	Sex 1XM 2□F	7. Age (In yrs 87	. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird March De March Z	$0^{\gamma_{\Theta\Theta}r)}1$	916 <sup>9. Bi</sup>	irthplece (State of Trypinia	
		pur *		Usuel Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside C	ity Limits
00		Maryli B-f eho	to	Maryland Freder	rick		ederic								1 Yes	2 🗆 No
145		th with the 23a or 28 ust be not	ai Dire	10e. Street and Number 2100 Wayside I	Orive, Ur	nit 1B		10f. Zip	Code 2170	2			10g. Citiz U.S	en of What C	Country?	
T.0.D	36	be filed within 72 hours after death with the Maryland tal Hygiene.  vd other than "neturel", or Items 23a or 28a-f show event, it a Medical Examination matter molified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Fo	edent Ever in lirces? 2 1 No. ve 1 944-1 ates:	u.s. 13.	Was Deced If Yes, spec 1 ☐ Yes :		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		4. Race - Am Black, Wh Specify: Wh		
+	00-9	2 hour	ted b	15. Decedent's	Education	ates:	16a Dece	dent's Usua	I Occupa	ation		in a	16b. Kin	d of Busines	s/industry	
	21215-0036	within 7 ene. than *n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1	1-4or 5+)	1	kind of wor DO NOT us ctrice				ang	Go	vernme	ent	
		e filed v il Hygie other t vent, th	e Co	17. Father's Name (First, Middle, La			LIC		ar r	18. Mothe	er's Nam	e (First, Middle,	, Maiden S	Sumame)		
0	ylan	2 should be fi and Mental H is marked of	To Be	John Alexander		Sr.						Pleasar				
70-62-1	Maryland	s 1 and 2 should I Health and Mer tem 27 is marke other traumatic		Mrs. E. Marguer:		wife						it 1B, I			Zip Code) MD 2170	2
	Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 any injury or other tru ance.		20a. Method of Disposition 14∑ Burial 2 ☐ Cremation 3 14☐ Donation 5 ☐ Other (Spe		State Ur	Place of Dispo cemetery cre 110n Cel	osition (Name matory or o Meter	ne of ther place y	feb.	4, 2	Date 2004			or Town, State Virgin	ia
D.0.D.	Balt	permit. Departr Importe any inj		21. Signature of Funeral Service Lin	Dry	MOC	)255	keene 106 E	y Adam ast	්ර්ජිස් Churc	Yforch Si	d PA Fur t., Free	neral deric	Home k, MD	1	
of K. Hope	87605	Physician /Medical Examiner	ilcai Examiner	23a. Part1. Enter the disease, or constant shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a conse	oquence of):		,	_		ascula		lase	Approxima Interval Be Onset and	tween Death
Forres	.O. Box 68	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ointh 2 ☐ Fe nant at time of	tel death 3[	⊒Ectopic pr ⊒Other (sp					2	3d. Date of d Month	delivery Day	Year
90	S, P	The law requires that the ate has been signed by th page 2 should be detache	þ	Part II. Other significant condition	s contributing to d	eath but not re	sulting in the u	inderlying c	ause give	en in Part I	l.	23ø. Did 1			to the cause of	
00	Record	w requi	ieted	10mbertion	e house	111	1/1/		llse	gen	71	24a. Was			autopsy findings o completion of	
phypilians	I Re		Completed	- whise is	- / Clar	n pr	usew	Ц				auto perfo 1 Yes	psy ormed? 20 Mo	prior to death	?	cause of
36	Vital	iician: Th certificate rector, pag	Be	25. Was case relerred to medical examiner?	Hospital:				Oth	ar		th (Check only				
J. C.	of	Attanding Physician: r death. sctor: After this certific by the funeral director.	n; To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date		28b. Time of Injury		28c. Injury Work	4 11 11	ursing H	ome 5 ☐ Resi 28d. Describe		Other (Sp occurred	pecify)	
0	Division	Attendin death. ctor: Afr y the fur	catic	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion			М	1 🗆	Yes 2□	No No	OOL Laanting (	(Ctt		Rural Route Nu	
Kt	Ω	afor Attan safter deat   Director: d in by the	Certification;	4 ☐ Homicide determin	200. Place	of Injury - At ing, etc. (Spec	home, larm, st cify)	reet, factory	, office			City or To			nurai noute ivui	11001,
change to		To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	ledical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the seminer: On the band man	best of my ki asis of examin	nowledge, deal	th occurred	at the tim	ne, date ar pinion, des	nd place ath occu	, and due to the rred at the time,	cause(s) date and	and manner place, and d	as stated. lue to the cause	s)
5		To the within 2 To the complet	Me	29b. Signature and title of certifier				290	c. License	e numb <i>e</i> r			29d. Date	signed (Mc	onth, Dey, Year)	
		.~	/	· alli	All	Kin	atth	MD	1	35	78	3	//	130	/20	204
		1.0		30. Name and address of person w	nó completed caus	od death (Ite	PC Type	, Print) Za	U	) 9	Ath	SI	F	eder	rok 1	no
		Sta Registr		31. Date liled (Month bay, Year)	04 12. F	tegistrar's Sign	ature									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 2004 SAMUEL HARAD 1:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 SLADE AVENUE #316 BALTIMORE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 11, 19 9. Birthplace (State or Foreign **Funeral** Hours 1₩ 2□F 85 11, PENNSYLVANIA 204-05-4508 Director Usual Residence of Decedent 10b. County BALTIMORE 10c. City, Town or Location BALTIMORE 10a. State 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ehow the Medical Examinar must be notified at MD 1 Yes 2 No Funeral Director 10f. Zip Code 21208 7 SLADE AVE., #316 10g, Citizen of What Country? ÜŠÄ 12. Was Decedent Ever in U.S. Agned Forces? 1 1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 3X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) OWNER FLOOR COVERING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ABRAHAM HARAD ANNA BORKIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is any injury or other trausons. MRS. MERLE SETREN (DAU) 16 SHADED GLEN CT. OWINGS MILLS, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Kirial 2 Cremation 3 Removal from State BETH EL MEM. PARK 2/4/2004 RANDALLSTOWN, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fineral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Pnysician onges /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68769 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊡triknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has I 1 ☐ Yes 2 100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Mesidence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 PNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 20 To the Hospitel within 24 hours a To the Funerel C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item-23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		4	For State Ragistrar	State of	Maryland		artment of F	lealth and N Death	1	Reg. No. 21	004	03280
	Physicia /Medic	an	1. Decedent's Name (First, Middle, L	Lee		Hor	ne		2. Date of De. Month	Day 4, 2	-	3. Time of Death 4.5% A M
js.	Examin	Ğ		spital (	cer) Center . Age (In yrs. I		· -	r Location of Death  PST min S  If Under 24 Hrs.	8 Date of Bird	th	9. Birthp	lece (State or Foreign
*	Funeral Director		213-26-2785		74	Yrs.	Months Days	Hours Min.	April Da	y, Year 1929	W\$E	Meville, VA
	Aaryland f show		Usuel Residence of Decedent           10a. State         10b. County           MD         Carro	L1	, Town or Lo							
	a or 28a-	Funeral Director	10e. Street and Number 4227 Backwoods	Road			10f. Zip Code 21158	3		10g. Citizen of V USA	Vhat Coun	ntry?
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturel", or items 23a or 28a-f show event, the Medical Examinational be notified at		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Date	as? A No		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	- 14. Race Blace Specify	e Amend k, White, Wh:	etc.
215-0	thin 72 house.	Completed by	15. Decedent's (Specify only highest statementary/Secondary (0-12)	Education rade completed) College (1-	4or 5+)	(Give life.	DO NOT use retire	during most of world	king	16b. Kind of Bu		dustry
Maryland 21215-0036	ag la g	Be	7th  17. Father's Name (First, Middle, La Robert Gullion	st)		Cler	k	18. Mother's Nam	ne (First, Middle,	Sale Maiden Sumam		
Mary	ges 1 and 2 should by t of Health and Menta If item 27 is merked or other traumatic events.	<u>م</u>	19a. Informant's Name/Relationship Mrs. Janet L. Wh		ughter	19b. Maili 4227	ng Address (Street Backwood	and Number or Ru ds Road,	ral Route Numb Westmin	er, City or Town, ster, MD	State, Zip	Code) 58
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 iry or other tr		20a. Method of Disposition  1 🕅 Burial 2 Cremation 3  4 Donation 5 Other (Spe			emetery, cre	osition (Name of matory or other pla Methodist	ce) t Cem. Fe	Date b.9,200	20c. Location · Myersv		
Balti	permit. Page Department Important: h any injury o		21. Signature of Funeral Server Lie	Ols	ne	E	LINE FUNE		Reister	stown,		
	Physician /Medical		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (final disease or condition resulting in death)	aa	used the deat ich line.		Sepsis		or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events	b. Due to (d	or as a conseq	uence of):						
3760,	ate be executed ysician and he burial-transit	cal	resulting in death) Last	Due to (d	or as a conseq	uence of):						
O. Box 68	The law requires that the death certificate be exite has been signed by the attending physician bage 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown		rth 2∏Feta ant at time of d	death 3	□Ectopic pregnanc □ Other (specify) _	у			te of delive	ery Day Year
Ω.	luires that t signed by	by	Part II. Other significant condition	s contributing to de	ath but not res	ulting in the	underlying cause gi	ven in Part I.		tobacco use cont Yes 2☑No	tribute to the	he cause of death? pably 4 [Unknown
Records,		Completed					<u> </u>		24a. Was auto perfe 1  Yes	psy ormed2	prior to co death?	opsy findings available impletion of cause of
Vital	Physician: The this certificate har director, page	o Be C	25. Was case referred to medical examiner?	Hospital:	npatient 2	ER/Outpatie	ent 3 DOA	26. Place of Dea		one)	ner (Specil	(v)
on of	ding Ph ). After th funeral	<del> </del>	27. Manuar of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of (Mont	of Injury h, Day Year)	28b. Time Injury	of 28c. Inju			how injury occur		
Division	el or Attendi s after death. I Director; A d in by the fu	27. Many r of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of North N								ber or Run	al Route Number,	
	To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the	Medical C	29a. Certifier 1 ✓ Certifying (Check only one) 1 ✓ Medicel E	Physician: To the caminer: On the ba and mann	asis of examina	owledge, dea ation and/or i	ath occurred at the t nvestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time.	cause(s) and ma , date and place,	anner as s and due t	stated. o the cause(s)
	To the To the Comp	W	29b. Signature and title of certifier	John (	grade	MP		se number 005994	3	29d. Date signe		Day, Year)
	6			EI, MO	295	Stor	e, Print)  Ave.	Soite	307 N	iestminst	er,	MO 21157
	Regis		31. Date filed (Month, Day, Year)	A	egistrar's Sign	ature	Si .					_
U	HMH 17 Rev 1/	2001		ř.		ORIGII	VAL					

		1	State Registrar AMEND ITEM #30	State of Mary PER DVR G828					iene <sub>9. No.</sub> 200	4 03281
		_	Decedent's Name (First, Middle, Last)		<u> </u>			2. Date of Deat Month		3. Time of Death
	Physicia		Robert Hersche	r				January	26°, 2004	3:30 AMM
7	Examiner 44. Facility Halife (if the literature), give shoet and trainedly							4c. County of D		
*			Prince George's			Clinton	If Clarley O.4 Line	100 (8:11	Prince (	
	Funeral Director		5. Social Security Number 6. Sex 1 🖾		yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 24,	1941 9.	Birthplace (State or Foreign Country) UNK
	DC .	-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	larylan show	5	DC		Washin					1 ☐ Yes 21 No
	28a-1	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	t Country?
	Se or	٥	1717 Columbia Road			2000	)9		USA	
	death ms 2	nera	11. Marital Status unk 12	2. Was Decedent Ever Armed Forces?	r in U.S. 13. \	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-		American Indian, Vhite, etc.
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23e or 28e-f show important: If item 27 is marked other than "natural" or items 23e or 28e-f show any figury or other traumatic event, Ite Medical Examinar must be motified at once.	Completed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	unk	1 ☐ Yes 2 💢 No	Specify:	o i mouri, oto.,	Specify: 1	
21215-0036	72 hou	eted	15. Decedent's Education (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of wor		16b. Kind of Busine	ess/Industry unk
121	within ane. than	dmo	Elementary/Secondary (0-12) unk un	College (1-4or 5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	DC NOT BBO TOURGO,	/			
2	filed Hygie other	Be Co	17. Father's Name (First, Middle, Last)			unk	18. Mother's Nar	ne (First, Middle, I	Maiden Surname)	unk
Maryland	2 should be filed within and Mental Hygiene. is marked other than raumatic event, the Ms.	To B								DIT-
lan	2 should and Men is marke sumatic		19a. Informant's Name/Relationship (Typ			ng Address (Street a				
	1 and 2 Health tem 27 i		Prince George's Me		er 30 20b. Place of Dispo	001 Hospit	tal Drive		n, MD 20 20c. Location - City	
Baltimore,	Pages 1 nent of H int: If ite iry or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 ☒ Other (Specify)	moval from State	cemetery, crer	matory or other plac	θ)	Date	zoc. Location - Oily	, or rown, state
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License Round d S W	ade, vivec	to,r St	Name and Address tate Anato Altimore.	omy Boar	d 655 W.	Baltimor	e Street
	Pnysician /Medical Examiner	_	23a. Part : Enter the disease, of compile shock or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):	ter the mode of dying	g, such as cardia	c or respiratory arro	est,	Approximate Interval Batween Onset and Death
8760,	cate be executed oblysician and the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Chesase of Injury that indicated events resulting in death) Last	Due to (or as a co						
P.O. Box 6	death certific e attending p id for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡ No 9 □ Unknown	ic. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Date of Month	delivery Day Year
	w requires that the s been signed by th s should be detache	d by Pł	Part II. Other significant conditions con	ributing to death but n	at resulting in the u	inderlying cause give	en in Part I.			te to the cause of death?  Probably 4 <del>GUnknow</del> n
Division of Vital Records,	e law has b	ompiete	Cordine !	ailre				24a. Was a autops perfori	ned? prior	e autopsy findings available r to completion of cause of th? Yes 2 \sum No
ita	ician: Th	Bec	25. Was case referred to medical examiner?	/			26. Place of De	ath (Check only or	(0)	
>	ys Is		1 Yes 2 No	ospital: 1 Inpatient	2 ER/Outpatier		4 Nursing F		ence 6 Other (	Specify)
o uo	ding After fune	atlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yo	ear) 28b. Time o	Wor	yat k? Yes 2 □ No	28d. Describe ho	ow injury occurred	
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, st Specify)	reet, factory, office		28f. Location (S. City or Town		or Rural Route Number,
	he Hospi n 24 hou he Funer pletely filt	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of n er: On the basis of ex and manner stated	amination and/or in	nvestigation, in my o	pinion, death occ	urred at the time, d	ate and place, and	due to the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of certifier	Berz	Mes	29c. Licens		36	9d. Date signed (A	100th, Day, Year)
			30. Name and address of person who co			, Print)	- (0			
			CHALAKOMER BERZING	32: Registrar's		S MEDICAL CI	ENTER C	LINION, MD.		
	St Regist	ate rar	31. Date filed (Month, Day, Year)	, A	July 1	asie				

		For State Registrar	State of Ma	-	•	rtment of H			Re	g. No.	2001	03	282
Physicia /Medic		1. Decedent's Name (First, Middle, Last Norvell Hall							2. Date of Deatl Month Januar	Day	200°	3. Time of 2.2	f Death
Examin		4a. Facility Name (If pot institution, give	uRitur			4b. City, Town, or	lt in	10/4	2	4c. C	ounty of Dee	<u> </u>	
Funeral Director		137-14-9203	X ŽM 2□F	9 (In yrs. last birt	Yrs.	Months Days	If Under Hours	Min	B. Date of Birth (Month, Day, Dec 1,	1924	9. Air	thplace (State buntry)	unk <sup>o</sup> n
tiled within 72 hours after death with the Maryland stylene. The stylene are stylene 1.2 or iteme 23e or 28e-f ehow ont, tra Medical Examinar must be notified at	ctor	Usuel Residence of Decedent  10a. State 10b. County  MD	a. State 10b. County 10c. City, Town or Location										City Limits
23e or 2	al Dire	10e. Street and Number 6116 Belair Road				10f. Zip Code 21	206		10	0g. Citize	n of What Co USA	ountry?	
I Health and Mental Hygiene. It health and Mental Hygiene. It marked other than "natural", or itame 23e or 28a-f show other traumatic event, if a Medical Exerciter must be rotified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	1127		Was Decedent of H Yes, specify Cuba □ Yes 2\ No			ify Yes or No- ican, etc.)		Black, Whit	encan Indian, e. etc. lack	
ene. then "natur	Completed	15. Decedent's Elementary/Secondary (0-12)	ucation de completed) College (1-4or s unk		Deced (Give life. D	lent's Usual Occup kind of work done i DO NOT use retired	ation during mosi d)	t of working	unk	16b. Kind	of Business	/Industry	unk
nd Mental Hygiene. marked other than imatic event, it a Mi	To Be Co	17. Father's Name (First, Middle, Last)				unk	18. Mothe	r's Name (	First, Middle, N	Maiden Su	ımame)		unk
Health and Mental tem 27 is marked of		19a. Informant's Name/Relationship (7 Good Samaritan				g Address (Street 1 Loch Ra				-		Zip Code) 239	
Definit. Pages 1 and Department of Heal Important: # Item 2 any injury or other page.	Í	20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		cemeter	Dispos ry, crem	sition (Name of natory or other place	(0)	Da	te	20c. Loca	tion - City or	Town, State	
Departin Departin Imports any inju		21. Signatur Funer Service Licent	Nade Dir	ector	S B	Name and Addrestate Anatal	ss of Facilit Comy ]	Board 2120	655 W.	Bal	timore	Stree	t
Physician /Medical Examiner		23a. Phrt. Enter the disease, or companies shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	one cause on each li	d the death. Do note.	Cid	er the mode of dyin	g, such as	Cardiac or	respiratory arre	est,		Approxima Interval Be Onset and	rtween
certificate be executed ding physician and lise as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading of introducts cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last	c	a consequence									
attending p for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   5   Other (specify)   9   Other (specify)   9   Other (specify)   9   Other (specify)   9   Other (specify)   9   Other (specify)   9   Other (specify)   9   Other (specify)   9   Other (specify)   9   Other							230	23d. Date of delivery  Month Day Year			
requires triat the or been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to											
ate has	Completed								24a. Was an autops perform	y	24b. Were as prior to death?	utopsy findings completion of 2 No	available cause of
g	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	ent 2 P/Ou	itpatien	t 3 DOA Oth	00		(Check only only only only only only only only		☐Other (Spe	cify)	
After	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			Time of njury	M 1 🗆	yat k? Yes 2□	No	3d. Describe ho			ural Route Nu	mher
Hospital of Attend 4 hours after death Funeral Director: , tely filled in by the f		4 Homicide determined	286. Place of in	tc. (Specify)		eet, lactory, office	na date an		City or Town	n, State)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only one)  2 Medical Example one)	iner: On the basis of and manner st	of examination an ated.	id/or inv	vestigation, in my o	pinion, dea e number	th occurred	d at the time, da	ate and pl	lace, and due	to the cause(	
		30. Name and address of person, who	completed cause of	death (Item 23a)	(Type:	Print) Brint	lvd	30	himo	Me	wolas	2021	239
Sta	te*	31. Date filed (Month, Dey, Year)	32. Regist	rar's Signature	has	6)	-4.		1	2		ICA DI	-/1

			1 - For State Registrar	State of M	laryland	-	artment of tificate of		and Mental Hy	Reg. No. 2	004	0328
	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Las  Donald R. Irv  4a. Facility Name (If not institution, give	vin Jr	ial Le	nter	4b. City, Jown,	VAPOL	is, MARYL	Day  26  4c. County	une	3. Time of Death  10 40AM  Arunde
	Funeral Director		5. Social Security Number 191–28–2853  Usual Residence of Decedent	9X 7. A(	ge (In yrs. las 67	t birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. 8. Date of B Min. (Month, D May 2	irth Pay, Year) 1936	9. Birthpi Coun Penn	lace (State or Foreign try) nsylvania
	e Maryland Sa-f show	ctor	10a. State 10b. County	Arundel	10c. City, 1		cation nnapolis		131		10	0d. Inside City Limits 1 ☐ Yes 2X No
	ith with the 23a or 24	al Director	10e. Street and Number 19 Oak Court				10f. Zip Code	1401		10g. Citizen of V		try?
920	d 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 Is marked other then "naturel", or Items 23a or 28a-f show traumatic event, the Medical Examer must be rollined at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No		Vas Decedent of f Yes, specify Cui I ☐ Yes 2∏ No		gin? (Specify Yes or N I, Puerto Rican, etc.)		ce - Amenc ck, White, e	etc.
21215-0036	d within 72 ho pene. r then "natur the Medical	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5+		(Give life.	lent's Usual Occu kind of work done DO NOT use retire unselor	pation during most ed)	t of working	16b. Kind of B	usiness/Ind	
8	should be filed and Menta! Hygie marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last)  Donald R. Irwin,					Et	r's Name (First, Middle	e, Maiden Suman †Z	ne)	
ē,	Heall Heall tem 2 other		19a. Informant's Name/Relationship (7 Phy11is N. Gehma  20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify	n.friend	20b. Plac	19 e of Dispo		rt Ann	ar or Rural Route Numb apolis, MD Date	1277-2701		
Baltil	permit. Pages Department of Important: If i any injury or 20029.		21. Sign ture of Euneral Fryice Licens ROP I d S.	şee . //	estor		. Name and Addr ate Ana Itimore.		y 21201 655 W	. Baltim	ore S	treet
•	Physician /Medical Examiner		23a. Rart1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	d the death. ine. Whatie a consequen	Do not ent	ncer of	ung, such as	cardiac or respiratory a	mary		Approximate Interval 8 etween Onset and Death
8/60,	ate be executed hysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infilated events resulting in death) Last	c	a consequer							
י מסע פ	death certific e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3	Ectopic pregnand Other (specify)	у		23d. Dal Mo	te of deliver	y Day Year
ras, r	sign d be	ρ	Part II. Other significant conditions co	intributing to death b	out not resultir	ng in the ur	derlying cause gr	ven in Part I.		tobacco use conti Yes 2 □ No		a cause of death?
I Hec	ine law ate has b page 2 s	Completed							24a. Was auto perfi 1 🗆 Yes	ppsy ormed?	prior to com death?	sy findings available ipletion of cause of
	ing Phyeici After this ce uneral direc	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 10  27. Manner of Death Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpation 28a. Date of Inju (Month, Da	ıry 28	/Outpatien b. Time of Injury	28c. Inju	ner: 4 ☐ Nur				)
	lei or Attendi s after death. el Director: A ed in by the f	Certification;	3 Suicide 6 Could not be determined	286. Place of In	jury - At home tc. (Specify)	, farm, str	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rurai	Route Number,
	I o the Hospitel or Attending within 24 hours after de To the Funerel Directe completely filled in by the	edical	29a. Certifier (Check only one)	sician: To the best iner: On the basis o and manner st	of examination	dge, death and/or inv	occurred at the t estigation, in my	me, date and opinion, deat	d place, and due to the h occurred at the time,	cause(s) and ma date and place, a	nner as sta and due to t	ited. the cause(s)
,	within 24	×	29b. Signature and title of certilier	_ CH	uspital	list)	29c. Licen		58	29d. Date signed		
			30. Name and address of person who called	ompleted cause of c		la) (Type, 1	Medi.	cal Po	rkway	ANNA	eus_	nd 21401
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registr	rar's Signature		Carles	·				

		•	State of Maryland / Department of Health and N  1- State Registrer Certificate of Death		ene 3. No. 2004	03284					
P	Physicia		1. Decedent's Name (First, Middle, Last)  MARGARET JONES	2. Date of Death Month	Day Year 30 Zoo	3. Time of Death					
	/Medic Examin	al .	4a. Fecility Name (If not institution, give street and number)  ADORTH WEST HOSPITAL  4b. City, Town, or Location of Death Randallstown	1	4c. County of Dee Baltin	th					
1. The same of the	Funeral Director		5. Social Security Number 216-09-1458  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 83 Yrs.  1 Months Days Hours Min.	8. Date of Birth (Month, Day,	rear) Co	thplece (State or Foreign ountry)					
	ryland		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 □ No					
	the Ma	recto	M.D. N/A Baltimore  10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co						
	th with	ai Di	1100 Pennsylvania Avenue Apt.313 21201		U.S.A						
36	within 72 hours atter death with the Maryland ene than "naturel", or Itams 23e or 28e-f ehow the Medical Exacilier most be notified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married 3 Married 3 Married 4 Divorced 4 Divorced 4 Divorced 4 Divorced 5 Married 5 Married 5 Married 5 Married 6 Married 6 Married 7	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: 13	te, etc.					
Maryland 21215-0036	s within 72 hou piene r than *nature tre Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)		6b. Kind of Business	/Indu <i>s</i> try					
and 21	be filed ital Hygi id other event, t	Be	8th Clerk  17. Father's Name (First, Middle, Last)  John Henry Brown  Edith	ne (First, Middle, M.		Industries					
Mary	and and sm	L L	19a. Informant's Name/Relationship (Type, Print)  David Jones – Son  19b. Mailing Address (Street and Number or Ru.)  3402 Lynchester Rd.	ral Route Number.							
	s 1 and 2 if Health item 27 l		20a. Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City or						
Baltimore,	permit. Pages. Department of Important: If ite any injury or of		Arbutus Mem. Park 2/7/								
Bal	Departiment Depart		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Nu 2501 Gwynnsfalls	Pkwy B	alto.,M.						
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	or respiratory arres	ot,	Interval Between Onset and Death					
	/Medical Examiner		Due to (or as a consequence of):  PNEUMONIA								
	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)								
,092	ate be executed sysician and he burial-transit	Ical Examiner	resulting in death) Last  C.  Due to (or as a consequence of):  d.								
P.O. Box 68	The law requires that the death centificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ysician/Med	ysician/Med				Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	livery Day Year
	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  CHROWIC OBSTRUCTIVE PULMONARY DISEASE		23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unkno						
Records,		Completed		24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of					
Vital	iclan: certific ector.	Be	examiner?	ath (Check only one							
of	Phys this rat din	n: To	27. Manner of Death 28a. Day Organ 28b. Time of 28c. Injury 28b. Time o	lome 5 Resider 28d. Describe how	nce 6 Other (Spe v injury occurred	ecify)					
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	1 Natural 5 Pending (Month, Day 16a) Injury Wolk? 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or R State)	iural Route Number,					
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier  (Check only   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	e, and due to the car pried at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)					
	To the I within 2 To the I	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number		d. Date signed (Mon	-					
	1		D54357		JANUARY	30 2004					
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITCLEA TO NOTITHWEST HOSPITAL SHELL OLD COURT ROAD RA		m uwa	D 21133					
3	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  FEB 0 5 2004  32 Registrar's Signature								

			State of Maryland / Department of Health and N  State Certificate of Death		jiene 20	04 03285
			Decedent's Name (First, Middle, Last)	2. Date of Dea Month		3. Time of Death
	Physici /Medic		Emma D. Kelley	January		04 10:50 AM
	Examir		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of	
			Southern Maryland Hospital Clinton	,		e George's
1	Funeral		5. Social Security Number 6. Sex 1 M 2 K F  7. Age (In yrs. last birthday)  1. If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)
	Director		223-40-2896	Oct. 10	, 1910	Virginia
	and w		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	the Maryland r 28a-f ehow	to	Virginia Henrico Sandston			1 ☐ Yes 2 🏋 No
-	28a	Director	10e. Street and Number 10f. Zip Code	1	I0g. Citizen of Wh	nat Country?
50	death with the Maryland rms 23a or 28a-f ehow rmst be notified at	al D	3883 Rising Mount Zion Road 23150		U.S.A.	
2	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race	- American Indian, White, etc.
7 9	after or Its	Fu	1 Never Married 2 Married 1 Yes 20 No	moan, etc./	Specify:	, white, etc.
~ E	within 72 hours after ene. then "netural", or Ite he Medical Exemine	d by	34 Wildowed 4 □ Divorced Year or Dates:			Black
	nat net	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work iffe. DO NOT use retired)	ring	16b. Kind of Bus	iness/Industry
5	withir then	E D	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		Own Ho	nma
) 7	be filed within tal Hygiene. Id other than event, the M	ပိ	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle,		
3   1:50 Am   -17	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Max	To Be	Armstead Richardson Harrie	t Conway		
0 5	permit. Peges 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked. any injury or other traumatic evone.	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rui	al Route Number	r, City or Town, S	tate, Zip Code)
50	alth a		Harriette K. Depriest / Daughter 3707 Garland Ave. F	Richmond	, VA 23	222
7	item of He		comptent are material as other place.	Date	20c. Location - C	ity or Town, State
	Pege nent ant: If	1	1 △Burial 2 □ Cremation 3 □ Removal from State  1 △ □ Donation 5 □ Other (Specify)  Rising Mt. Zion Bapt. Ch.	1/21/04	Sandsto	on, VA
	mit. portrigority injurial		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Manning Funeral He	ome.		
A Ja	3 405 5 8		d Lennis Villani 700 N. 25th Street	Rich	mond, VA	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. METASTATIC SLADDER	ANCE	R	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
	Examiner # 4	l-	Squential, list conditions b. Due to (or as a consequence of):			
	2 be tise	nine	Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
(X)	be executed ician and burial-transil	Examiner	that initiated events c.  resulting in death) Last Due to (or as a consequence of):			
(19/	ate be executhy sician and the burial-trans	cai E				
89		<b>1</b>	0.			-
₹ 8	ath certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date	of delivery
A. 4	death e atte	Cla	in the past 12 months?  1		Mont	h Day Year
2 3	by the stached	hys	9 Unknown			
MM	The law requires that the death certific that been signed by the attending page 2 should be detached for use as:	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
7	v require been si should I	ted		1 🗆 Yı	es 2□No 3	Probably 4 Unknown
Fords	e law r has be	Completed		24a. Was a	n 24b. We	ere autopsy findings available or to completion of cause of
_ 0		Ş		noneq	med?   de	ath? ☐Yes 2∭(No
	Physiclan: Th rthis certificate	Be (	25. Was case referred to medical examiner?			
LE	Physic this o	P	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Reside	ence 6 Other	(Specify)
		lon:	27. Manner of Death  ↑ Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?	28d. Describe ho	ow injury occurred	1
T) :	tend for: the	cat	2 Accident investigation M 1 Yes 2 No	201 1		
KEL	or Attendate death	Certification:	3 ☐ Suicide 4 ☐ Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town		or Rural Route Number,
_	Hospitel or the hours after Funeral Dir tely filled in tely filled in the hours at the hours after the hours a		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.	and due to the c	ause(s) and man	ner as stated
	To the Hospitel or Al within 24 hours after or To the Funeral Directompletely filled in by	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, d	ate and place, an	d due to the cause(s)
	To the within 2 To the comple	×	29b. Signature and title of certifier 29c. License number			(Month, Day, Year)
	4.1		D53885		1/18	MD 20735
	4		30. Name and address of persop who completed cause of death (Item 23a) (Type, Print)	12.2 0	, , ,	112
	\		VENKAT. S KAMANAN 7501 SURRATTS KORD #	307 C	LINTON	M) 20 735
	Sta Regist	ate	31. Date filed (Month, Day, Year)  Sepsitrar's Signature  FEB 0 5 2004  Sepsitrar's Signature			
	negist	rui	LU V LUUT partel			

DHMH 17 Rev 1/2001

State Registrar

DHMH 17 Rev 1/200

30. Name and address of person wit

31. Date filed (Month, Day, Year) FEB 0 5

MARCIARITA

HURELL

2004

Souls!

DR. RIPPLE FUR

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JANUARY

111 Penn Street, Baltimore, Maryland 21201

			_ For	State of Maryland	/ Depa	rtment o	f Health and		/giene	
			1 - State Registrar		Cer	tificate c	of Death		Reg. No. 4	104 03287
	Physici	an .	Decedent's Name (First, Middle, Last)					2. Date of D	Day	3. Time of Death
	/Medio		JAMES HOPPE	ER LYON				JANUAR	1 29 3	2004 533 PM
>	Examir	ier	4a. Facility Name (If not institution, give s			4b. City, Town	n, or Location of Dea	ith	4c. County	y of Death
				HINGTON ST.		HAVR		ACE		REORD
и	Funeral		5. Social Security Number 6. Sex	M 2DE	t birthday) Yrs.	If Under 1 Ye Months Da			irth <i>ay, Year)</i>	Birthplace (State or Foreign Country)
H.	Director		219-18-0599 Usual Residence of Decedent	79	115.			02/02/	1924	Maryland
	land wo		10a. State 10b. County	10c. City, T	Town or Lo	cation				10d. Inside City Limits
	Many	jo	MD Harford	Цахи		Cuaca				1 XYes 2 □ No
	the 28a	Director	10e. Street and Number	пачт	e de	Grace	θ		10g. Citizen of	What Country?
	3a or		927 South Washing	ton Ct		2107			USA	,
	me 2	era	827 South Washing	12. Was Decedent Ever in U.S.	13. V		of Hispanic Origin? ( Juban, Mexican, Pue	Specify Yes or N		ce - American Indian,
(0	rita	Funerai	1 X Never Married 2 ☐ Married	Armed Forces? 1 XYes 2 □ No If Yes, Give				nto Rican, etc.)	Bla	ck, White, etc.
ğ	ours a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1942-L	15	☐ Yes 2X	No Specify:		Specif	y. White
21215-0036	d within 72 hours after death with the Maryland ljene. r than "natural", or itams 23a or 28a-f show the Medical Exant set must be tradified at	Completed	15. Decedent's Educ (Specify only highest grade	cation 1	6a. Deced	ent's Usual Oc	cupation ne during most of we	net in a	16b. Kind of B	usiness/Industry
21	within ene. then	npidu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	O NOT use re	rired)	, , , , , , , , , , , , , , , , , , ,		
2	filed w Hygier other th	ပိ		4 years	Phar	macist				Employed
밀	0 m 5 ×	Be	17. Father's Name (First, Middle, Last)						e, Maiden Surnan	ne)
yla	should nd Men marka umatic	ျ	George Taylor Lyo	-				Hopper		
Maryland	12 sh and ris n		19a. Informant's Name/Relationship (Ty)	1			eet and Number or F			
	1 and Healt em 2	1 10	George T. Lyon, J			JOPP:	a Rd., To	Date		
Baltimore,	Pages 1 and 2 should b nent of Health and Ments sut: if item 27 is marked ury or other traumatic e		1 XBurial 2 □ Cremation 3 □R	emoval from State cemi	etery, crem	atory or other ;	olace)			City or Town, State
Ħ	it Partmen		*4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License			I Cemet		02/04		de Grace, MD
Ba	permit. Page Department Important: if any injury o		A Signature of Furieral Service License	Smile	M	itchell-	Smith Fu	neral Ho	me, P.A	١.
		_4	23a. Part1. Enter the disease, or compli	cations that caused the death.	) 123	S. Wa	shington	, Havre	<u>de Grad</u>	ce, MD 21078  Approximate
		y d	23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	o not onte	* ***	lying, such as cardia	ic or respiratory a	arrest,	Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Myocar	diol	enfo	ration vascula			
B	Examiner			Due to (or a consequen	ice of):	Λ Λ	. ^	Λ	*-	
165		-	Saguentially list conditions b	Due to (or as a consequen	ice of):	Carde	vascula	s de	peares	
1	uted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,					
′.	be executed ician and burial-transit	Exa	that initiated events cresulting in death) Last	Due to (or as a consequen	ice of):					
760,	le be executed ysician and e burial-transit	call								
89	that the death certificate ed by the attending phys detached for use as the									
Вох	death certificat e attending phy id for use as th	N/N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy					23d. Da	te of delivery
	deati e atte	icia	in the past 12 months?	1 Live birth 2 Fetal de 4 Pregnant at time of death		Ectopic pregna Other (specify)			Mo	onth Day Year
P.O.	at the by th tache	hys	9 Unknown	9□ Unknown						
S,	S L 0	by Physician/Medi	Part II. Other significant conditions con		ng in the un	derlying cause	given in Part I.	23e. Did	tobacco use cont	ribute to the cause of death?
ıd	w require been signations bear signated by	ed	No	me				1 🗆	Yes 2 □ No	3 Probably 4 □Unknown
သူ	law re as be 2 sho	plet						24a. Was	an 24b.	Were autopsy findings available
m m	The ate his	Completed		-				auto perfe	ormed?	prior to completion of cause of death? 1 🗌 Yes — 2 🌋 No
ita	ian: ortifica ctor,	Bec	25. Was case referred to medical examiner?				26. Place of De	ath (Check only		
<u>&gt;</u>	hysic lidire	To	1 X Yes 2 No H	ospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient	3□ DOA	Other: 4   Nursing	Home 5 Res	idence 6 Oth	er (Specify)
0	ng Pl fter ti nera		27. Manner of Death 1   ■ Natural 5   □ Pending	28a. Date of Injury 28 (Month, Day Year)	b. Time of Injury	28c. lr	jury at Vork?	28d. Describe	how injury occur	red
0	endii eath. or: A	atle	2 Accident investigation			M 1	☐Yes 2☐No			
Division of Vital Record	ter de irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, offic	ce		Street and Numb wn, State)	er or Rural Route Number,
	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificitely filled in by the funeral director.		- 10	1						
	Hosp 24 hol Fune Fune tely fi	lical	(Check only 2 Medical Examin	ician: To the best of my knowled ter: On the basis of examination	dge, death and/or inv	occurred at the estigation, in m	time, date and plac y opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place,	nner as stated. and due to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29b. Signature and title of certifier	and manner stated.			nse number			d (Month, Day, Year)
	8 7 K 7		R OLVE	No Day E					Lou. Date Signer	
,	1x1		semand J from	WIN, DME			4206	,	JANKARY	30, 200 4
1	21			mpleted cause of death (Item 23	(Type, F	ABIRD	Ave Rai	to md a	1222	
4.	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	U JAN	TOIND	MAC THY	-וני בים כ	1666	
ijř.	Registr		FEB 0 5 2004	32. Registrar's Signature	dies.					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Jime of Death Day Physician 12:10am ,2004 Naomi Linderman Tanuaru 26 /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Bayview Medical Center Johns Hopkins If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 31, 1940 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 9. Birthplece (State or Foreign **Funeral** 1 □ M 2 K F 282-38-6601 63 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show Anne Arundel Millersville 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 262 Dogwood Road 21108 Funerai permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 3 any injury or other traumatic event, the Moderal Examinar manones. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 salesperson novelty stores 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Paul Price Dora Angeline Smith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Waugh/sister 7003 Northpoint Road Baltimore, MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State \* 4 X Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licer RODA LO S 23a. Part1. Enter the disease, or compocations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD **Physician** severe disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown been signed by should be detac Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Þ 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas page 2 autopsy certificate 1 Yes 2 XNo 25. Was case referred to medical examiner? Be funeral director 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Certification: To 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 1 Natural 2 Accident 5 Pending 1 TYes 2 □No investigation Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number Jan. 26, 2004 Res - 000 M.D.30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Baltimore, MD 2/224 4940 Eastern Dr. Tina Bau 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

0 5

**ORIGINAL** 

			For State Registrar	State of Ma		epartme Certifica				Re	g. No.	2004	03289
	Physici /Medio		1. Decedent's Name (First, Middle, Last Robert W.	Mead					F	ebruar	y <sup>D</sup> 3 <sup>y</sup> ,	200年	3. Time of Death 5:30 pm
}	Examir		4a. Facility Name (If not institution, give 4303 Conifer Cour	t		G	len A	Location o				ounty of Dea	re
e	Funeral Director		010 01 0102	X M 2□F 7. Age	62 Y	Months	Days	Hours	Min. Oc	B. Date of Birth (Month, Day, CTODER 2,	<sup>7</sup> 1941	. Cal	thplace (State or Foreign ountry) 1 Tornia
	e Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Baltimor	e	10c. City, Town								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with th	ai Dire	10e. Street and Number 149-B Versailles Circ	le			ip Code 21204			10	og. Citize USA	n of What Co	ountry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Department of Heatin and Mental Hygiene. Integrate: If Item 27 is marked other then "netural; or Items 23e or 28e-f show important: If Item 27 is marked other then "netural; or items 25e or 28e-f show eny injury or other traumatic event, Ite Medical Exam. are must be invitibled at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent I Amed Forces? 1 DYes 2 N If Yes, Give Year or Dates:	Ever in U.S. 40196/3- 1988		edent of H ecify Cuba 2 🛣 No	ispanic Orig n, Mexican Specify:	gin? (Speci , Puerto Ri	ty Yes or No- can, etc.)		. Race - Ame Black, Whit pecify: Whi	
1215-0	within 72 hor ene. then "netur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		+) (	Decedent's Us Give kind of w life. DO NOT	rark done o	turina most	of working		Law	of Business	Andustry
5	should be filed and Mental Hygid marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last)  Walter Donald	Mead				Pea	ar1	First, Middle, N	Eck1e	es	
	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (T) Rebecca M. Hergenroed							Route Number, MD 210		own, State, .	Zip Code)
Baltimore,	Pages 1 and the north of He north the north or other try		20a. Method of Disposition 1		Parkwood	Disposition (N crematory or Ceme te	ame of other place <b>Y</b>	θ)	Dat 2 <b>/7/</b> 04	1		tion - City or MOre, M	
Balti	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licens	<sup>eee</sup> William	G. Dau	22. Name :	and Addres 5 Harf	s of Facility	Leona	ard J. Ru timore, M	ck, I D 21	nc. Fun 214	eral Home
* }	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Ada	mo carc	et enter the mo	de of dyin						Approximate Interval Between Onset and Death
	death certificate be executed we attending physicien and der use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as :	a consequence of	):							)
	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 Ectopic 5 Other (					230	d. Date of del	ivery Day Year
ords, P	The law requires that the ste has been signed by th page 2 should be detache	þ	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in t	the underlying	cause give	en in Part I.			acco use s 2 🗆 I		the cause of death?
		Completed								24a. Was an autopsy perform	ed? No	24b. Were at prior to death?	utopsy findings available completion of cause of 2 No
Division of Vital	ding Phys h. After this funeral dir	ation; To Be	25. Was case referred to medical examiner?  1  Yes  No  27. Manner of Death  1 Natural	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	nt 2 ER/Outp y Year) 28b. Tir Inj		28c. Injury Work	or: 4 □ Nur	rsing Home	Check only one 5 Resider d. Describe hor	10e 6	Other (Speccourred	city) Established
1000	2 0 2 2	Certification;	3 \( \) Suicide 6 \( \) Could not be 4 \( \) Homicide determined	28e. Place of Injubulding, etc	ury - At home, farn c. (Specify)	n, street, facto	ry, office		28	f. Location (Str. City or Town,		lumber or Ru	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination and	death occurre or investigation	d at the tim n, in my op	e, date and pinion, deat	d place, and h occurred	d due to the car at the time, da	use(s) an te and pla	d manner as ace, and due	stated. to the cause(s)
•	To the comp	Me	29b. Signature and title of certifier	teet	- MD	2	Oc. License	188 E	GB.	29	d. Date s	igned (Monti	h, Day, Year)
1	XOX1		30. Name and address of person who c	'''	eath (Item 23a) (T	ype, Print)	1.D.	136 C	D Wi	TOPPA Le Ma	Foa	Suit	h, Day, Year) XY AC 30 (,
Sa	Sta Registr		31. Date filed (Month, Day, Year)	l A	ir's Signature	e de	sage?						

State of Maryland / Department of Health and Mental Hygiene 2004

03290

				Certificate of Death	Reg. No.	
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Dev Yea	3. Time of Death
	Physicia		Emily H. McFarland	l	JANNY 31 20	
3	/Medic Examin		4a Facility Name (If not institution, give street and number)		Location of Death 4c. County of De	-
-	L-Xarriiri	Ci	North Arundei Hospi	tal Glen Bu	Nie , MD Anne AR	
-	Eunoval		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth 9. B	intholace (State or Foreign
	Funeral Director			66 Yrs. Months Days Hours Min	May 02 1917	SC
	. ,		Usuel Residence of Decedent		11ay 02 1317	30
	/and	Ì	10a. State 10b. County 10c. Ci	ity, Town or Location		10d. Inside City Limits
	Mary	ŏ	Maryland Anne Arundel	Glen Burni	е	1 ☐ Yes 2X No
	# # # # # # # # # # # # # # # # # # #	ဦ	10e. Street and Number	10f. Zip Code	10g. Citizen of What 0	Country?
-	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or frems 23a or 28a-f show ant, the Medical Examiner must be mothed at	Funeral Director	105 Queen Anne	21060	USA	-
	eath	era	11. Marital Status 12. Was Decedent Ever in U			nerican Indian,
_	ter d	ا ج	Armed Forces?	J.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.) Black, Wr	nite, etc.
20	rs af	by §	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specity: W	<i>l</i> hite
, <u>ģ</u>	hou tura	8	15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Busines	elladusta
15	n 72	Completed	(Specify only highest grade completed)	(Give kind of work done during most of wo	orking Tob. Killd of Business	armoustry
12	with there.	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	House	hold
, p	Hygi ther int,	Š	17. Father's Name (First, Middle, Last)		me (First, Middle, Maiden Sumame)	:HOTU
a.	d d d	Be		Lilly		
Š	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", raumatic event, the Medical Exa	ို	Coy Holcombe			
Maryland 21215-0020	l2 st and is n		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or R		, Zip Code)
ď.	and lealth m 27		Darlene Schmitz (daughter)	109 Norman Road, Pas		
0.0	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be nothered.		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	FeBate 04 20c. Location - City of	
Ē	Pag ment: I			en Haven Cemetery	2004 Glen Burni	e, Maryland
Baltimore,	permit. Pages 1 and 2 of Department of Health an Important: If item 27 is any Injury or other trausings.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Stallings Funeral	Home, P.A.
m	Depa impo any l		11.0	2111 Mountain Doa	d, Pasadena, MD 21	122
			23a. Part1. Enter the 1 sease, or complications that cause 1 √ deal shock, or heart failure. List only one cause on ⇒ ch line	th. Do not enter the mode of dving, such as cardia	cor respiratory arrest	Approximate
	Dhusisian		shock, or heart failure. List only one cause on 3 ch line		,,,,,	Interval Between Onset end Death
	Physician /Medical		Immediate Cause (Final			
	Examiner		disease or condition resulting in death)	vas a consequence of):  Acris a consequence of):  And Francia		
п		-	Due to (c	or as a consequence of):		
	pe isit	n/Medical Examiner		admit to Fancion		
	certificate be axecuted nding physician and usa as the burial-transit	xau	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	or as e consequence of):		
68760,	be ay cian cunia	E	cause. Enter Underlying Ceuse (Disease or injury			
87	ate l	흥	that initiated events resulting in death) Last	or as a consequence of):		
9 xo	ing paras	Z E				
Bo	aath o attand I for us		<u> </u>			!
	res that tha daath signed by the attar I be datached for u	by Physicia	Part II. Other algnificant conditions contributing to death but not res	ulting in the underlying cause given in Part I.	23b. Did tobacco use contribut	te to the cause of death?
9.0	at the	چ			1 ☐ Yea 2 ☐ No 3 ☐ I	Probably 4 Unknown
S,	s th	5				
2	v require been sij should t	8			24a. Was an autopsy performed? 24b.	. Were autopsy findings available prior to
ပ္	w re	et			performed:	completion of cause of death?
æ	The law requires that tha daath ate has been signed by the attal paga 2 should be datached for i	Completed			1 Vas 22140	1 ☐ Yes 2 ☐ No
Division of Vital Records, P.O.		Ö	25. Was case referred to medical	GC Bloom of Do		1 162 2 140
Ē		Be	examiner?	Othor	ath (Check only one)	
of	Phys this rald	2		ENVOURDATION 3LI DON 4LI NUISING P	flome 5 ☐ Residence 6 ☐ Other (Sp. 28d. Describe how injury occurred	ecify)
5	After funer	<u></u>	1 ☑Natural 5 ☐ Pending (Month, Day Year)	28b. Time of lnjury at Work?  M 1 □ Yes 2 □ No	20d. Dosonbe now injury occurred	
Si	teath tor: tha	<u>  2</u>	3 Suicide 6 Could not be Ose Blace of taken At h		Opt I pretice (Charles of the base of	December 1
₹	frer cellines	늰	4 ☐ Homicide determined building, etc. (Specific	ome, farm, street, factory, office 'y)	28f. Location (Street and Number or F City or Town, State)	Hurai Houte Number,
	urs a	ပီ				
	Hosp 4 ho Fune	edicai Certification:	(Check only 2 Medical Examiner: On the basis of examina	wledge, death occurred at the Ime, date and place tion and/or investigation, in my opinion, death occu	e, end due to the cause(s) and manner a arred at the time, date and place, and du	is stated. le to the cause(s)
	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Att complately filled in by the fur		one) and manner stated.			
	5 <u>**</u> 5 00		29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	ntn, Day, Year)
	^		Ites I trong	0027415	JAprily	31, 2004
	1)	<b>-</b>	30. Name and address of person who completed cause of death (Item	n 23e) (Type, Print)		
	.,		HENRY L. FRANCIS MD	North Arundel	Huspita)	
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrer's Signa	ature	<del></del>	
10			FFD 0 5 2004 Ac.	hel dimendia		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2, Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 5:45 PM Myrtle Lena Mahan 2004 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hartord Hartord Memorial Hospital Grace Havre de If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/03/1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min. Months Days Hours 1 ☐ M 2 🗙 F 88 Maryland Director 212-30-4680 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other then "naturel", or Iteme 23e or 28e-f show other troumstic event, the Medical Examinat must be notified at 1 ☐ Yes 2 X No Director Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3610 Aldino Rd 21028 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Leonard Stearn Annie Hughes permit. Pages 1 and 2 sh.
Department of Health and Importent: If item 27 is many injury or .... 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3807 Rider Lane, Havre de Grace, MD 21078 Alvin Mahan- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Rock Run Cemetery 01/30/04 Havre de Grace, MD . Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. Dune 123 S. Washington, Havre de Grace, MD 21078 28a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early line. Approximate Interval Between Onset and Death Myocard:al Immediate Cause (Final disease or condition resulting in death) Intarction Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Urbanying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be axecuted and Due to (or as a consequence of): the attending physician thed for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Year Day 4 Pregnant at time of death 5 Other (specify) signad by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has director, page 2 autopsy performed? certificate 2 No 1 ☐ Yes Attending Phyelcian: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To this fillad in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 5 To the Hospital within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058904 26/2004 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Havrede Grace MD Avenue South Union 319 Ha J.

Registrar

State

31. Date filed (Month, Day, Year) FEB 0 5 2004

2. Registrar's Signature

			For State Registrar	State o	f Marylan		artment of H		nd Mental I	Hygiene Reg. No	711111	+ 03292
	Physicia		Decedent's Name (First, Middle, DORLIS J. Medical						2. Date o			3. Time of Death
	/Medic Examin	_	4e. Facility Name (If not institution,	give street and nur	nber) Bel Ail	~	4b. City, Town, or Bel Air	r Location of			County of Dea	
	Funeral Director		213-26-0728	3. Sex 1 □ M 2 <b>X</b> 2 F	7. Age (In yrs. ) 73	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	8. Date o (Month 2/15	Birth . <i>Day</i> , Year 5/1930	9. Bir C V <b>i</b>	thplace (State or Foreign buntry) rginia
	ehow	2	Usual Residence of Decedent  10a. State 10b. County  MD Harfo	rd	10c. City	, Town or Lo			-			10d. Inside City Limits 1 ☐ Yes 2 😿 No
	with the N a or 28a-f be notifi	Director	10e. Street and Number 2650 Dublin R				10f. Zip Code 21154			10g. Ci	tizen of What Co	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow apply injury or other traumatic event, the Madical Examinar must be mailfied at ODCs.	by Funeral	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Dece Armed Fo	2 XNo	'	Was Decedent of H	lispanic Orig an, Mexican, Specify:	gin? (Specify Yes o Puerto Rican, etc.	r No-	14. Race - Ame Black, White Specify: W	
Maryland 21215-0036	within 72 hou ne. than "nature ie wedical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most d)	of working		Cind of Business	
and 2	d be filed vental Hygie	To Be Co	11 17. Father's Name (First, Middle, L Oliver Lamber			HOIRE	maxer		r's Name <i>(First, Mi</i> r illie Fe)	ddle, Maider		
Mary	nd 2 shoul aith and Me 27 is mark r traumati	L	19a. Informant's Name/Relationsh William F. McNu						ror Rural Route Ni Street, 1		or Town, State, .	Zip Code)
Baltimore,	Pages 1 a nent of Mes int: If item iry or othe		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp		State Dai	lace of Dispo emetery, crer rlingt	sition (Name of matory or other place on Cemete	ery 2	Date 2/5/2004		ocation - City or Clington	
Balti	permit. Departminents Imports eny inju		21. Signal to of Funeral Service L	Tillett	4	H	2. Name and Addre	ss of Facility	me, Inc.,60	0 Main	st.,Delta	a, PA 17314
8760,	Physician and /Medical Examiner the private in the private interest in the private interest in the private in t	dicai Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Seve Due to b	~	uence of):	tia,	1n1+	infan	-f		Onset and Peath Several Year
P.O. Box 6	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1☐Live b	tcome of pregna birth 2   Feta nant at time of do own	Ideath 3	Ectopic pregnancy Other (specify)	,			23d. Date of de Month	livery Day Year
ds, P	juires that the signed by ald be detacted	by	Part II. Other significant condition  HISTORY  A	Multi	eath but not res	ulting in the y	nderlying cause giv	en in Part I.	†			o the cause of death?
c Nu+f- Vital Records,	ician: The law requir certificate has been s rector, page 2 should	Completed					4 ocide	nt_		Mas an autopsy performed?	prior to death?	utopsy findings available completion of cause of
of B	Attending Physic death. ector: After this by the funeral did	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide	28a. Date (Mon ation of be 28e. Place	of Injury th, Day Year)		f 28c. Injur Wor	ier: 4 Nui	No 28f. Locati	Residence ibe how inju	iry occurred  nd Number or R	ocify) ural Route Number,
000	Hospital or 4 hours afte Funeral Dir 1619 filled in		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the ixaminer: On the b	best of my kno	wledge, deat	h occurred at the tir vestigation, in my o	ne, date and	d place, and due to	the cause(s	and manner a	s stated. e to the cause(s)
	To the h within 24 To the F complete	Medical	29b. Signature and title of certifier	and man	ner stated.		29c. Licens		6500	.,	ate signed (Mon	
	9		30. Name and address a person v	who completed caus	se of d ath (Item	1 23a) (Type,	Print) 8 L	JW	Street	Hel	ruary	2, 2004
	Sta Registi		31. Date filed (Month Par Year)	2004 32.5	legistrar's Signa	ture	barle	ber	deen	Har	yland	100)

patient known as Joseph Mullins Baltimore, Maryland 21215-0036

			Please T		k Indelible Ink. Ensure	-	
			1 - For State Registrar	•	Department of Health and Certificate of Death	Mental Hygie Reg.	- 2001, 02201
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Joseph Mullins			2. Date of Death Month	Day Year 3. Time of Death 2:37 P M
20.	Examine Funeral Director	ner	4a. Facility Name (If not institution, give s  5. Social Security Number   6. Sex  233-50-7852	of Baltimore 7. Age (In yrs. last birth	4b. City, Town, or Location of Deat    Control   Control   Control	8. Date of Birth (Month, Day, Ye	
	D		Usual Residence of Decedent  10a. State 10b. County MD	10c. City, Town	or Location altimore	Oct 11, 1	933 10d. Inside City Limits
	with the Manual transfer or 28a-f	Funeral Director	10e. Street and Number 2525 W. Belvedere		10f. Zip Code	10g.	1X Yes 2 No Citizen of What Country?
036	within 72 hours after death with the Maryland sne. than "natural; or items 23s or 28s-f show the Madical Esamirier must be notified at	b		2. Was Decedent Ever in U.S. Armed Forces?  1	21215  13. Was Decedent of Hispanic Origin? (S II Yes, specify Cuban, Mexican, Puerl 1 \( \subseteq \text{Yes} \) 2\( \overline{X} \) No \( Specify: \)	pecify Yes or No- o Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	d within 72 ho piene. r than "natur the Wouldal	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) unk un	completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king unk 16b	. Kind of Business/Industry un
Maryland:	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Me	To Be C	17. Father's Name (First, Middle, Last)		unk 18. Mother's Nar	ne (First, Middle, Maid	den Sumame) unk
	es 1 and of Health fitem 27 r other tr		19a. Informant's Name/Relationship (Type Sinai Hospital  20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	20b. Place of cemetery	Mailing Address (Street and Number or Ru 401 W. Belvedere Ave Disposition (Name of v, crematory or other place)	enue Baltin	
Baltimore,	permit. Pag Department Important: I any injury o		*4 □ Donation 5 ★ Other (Specify)  21. Signature of Foreral Service License RODA Ld S. W		22. Name and Address of Facility State Anatomy Boar Baltimore, MD 2120	d 655 W. Ba	altimore Street
5	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ations that caused the death. Do not a cause on each line.  My or AP of Due to (or as a consequence of Due to (or as a conse	ot enter the mode of dying, such as cardiac lia Infanci f):	or respiratory arrest,	Approximate Interval Between Onset and Death
). Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \)	Due to (or as a consequence of c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	f): 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.O.	quires that the de n signed by the a uld be detached i		9 □ Unknown  Part II. Other significant conditions cont  Hypeziem Sid		the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
of Vital Records,		e Completed by	25. Was case referred to medical		36 Place of Dec	24a. Was an autopsy performed? 1 Yes 254	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  10
	ling Phys n. After this funeral dii	ation; To B	27. Manner of D ath   Natural 5   Pending   Pe	espital: 1 Inpatient 2 ☐ ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tir Inj	patient 3 DOA Other: 4 Nursing H	ome 5 Residence 28d. Describe how in	
Division	Hospitel or Attenc 24 hours after death Funeral Director: stely filled in by the i	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)		City or Town, Sta	
	To the Hospitel or within 24 hours after to the Funeral Direction letely filled in I	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one) Certi	cian: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and place, for investigation, in my opinion, death occur	red at the time, date a	nd place, and due to the cause(s)
	¥ 3 4 8		30. Name and address of person who co	Physicias pleted cause of death (tem 232)			nuary 24 2004  Altimore MU21215
	Sta	ite	31. Date filed (Month, Day, Year)	Registrar's Signature	2 101 w. Selvede	me Ave 6	SAltimore, mozizio
DH	Registr		FEB 0 5 200	Base As	Jole		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Konjancin Month Day 2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Sounty of Death M111enium Franklin Square Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10M 20 F Days 154-22-6461 72 Sept 5, 1931 Georgia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore TV Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1217 W. Fayette Street 21223 USA unk 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married I ☐ Yes 2 ☐ No If Yes, Give unk 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 nursing aide nursing home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridgette Hair/friend 4909 Frederick Avenue #B Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 XOther (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Roma Id S. Wad irector Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiovascular Dises Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last as e consequence of: Due to (or as e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? al No 1 Yes 1 ☐ Yes al No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 □ Yes 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

**Physician** /Medical Examiner The law requires thet the death certificate be executed attending physician end Box 68760, Division of Vital Records, P.O. signed to certificete has been si irector, page 2 should the funeral director. After this completely filled in by or A efter within 24 hours

**Physician** 

/Medical

MD

Director

Funeral

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Completed

Be

Examiner

by Physician/Medical

Completed

Be

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Certification:

Medical

(Check only one)

29b. Signature and title of certifier

Examiner

**Funeral** 

Director

filed within 72 hours after death with the Maryland r than "netural", or items 23e or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed will Department of Health end Mental Hygien. Important: If item 27 is marked other the any injury or other treumatic event, Ins. 2006.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

31. Date filed (Month, Day, Year) FEB 0 5 2004

5 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

RJI	)	4	For State Registrar		State of Mar	-	epartment of Certificate of			Reg. No. 2	004	03295
	Physici	an	1. Decedent's Name		umont	OD	EN		2. Date of De Month Febuar	Day	Yeer 2004	3. Time of Death 0227A. M
	/Medic Examin		4a. Fecility Name (If	not institution, give str	reet and number)			n, or Location of Dea	th		nty of Death	
	Funeral Director		5. Social Security Nu 220-17-	mber 6. Sex		In yrs. last birthe	Months Da			y. Yeer)	Coun	lace (State or Foreign htry) aryland
	anyland show	2		Decedent 10b. County N/A	1	Oc. City, Town	or Location +more	- City			1	0d. Inside City Limits 1 XYes 2 □ No
	with the M a or 28a-f be notified	Director	10e. Street and Num		h Gald		10f. Zip Coo	le		-	of What Coun	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23s or 28s-f show marked other than "natural", or Items 23s or 28s-f show maric event, the Modreal Examilies marit be notified at	by Funeral	11. Marital Status 1 Never Marrie 3 Widowed	d 2 Married	2. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent If Yes, specify 0	of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)		Race - Americ Black, White, ecity: B	
1215-0036	within 72 hou ene. then "natura he Musical E	Completed	(Special		ation completed) College (1-4or 5+)	(1	ife. DO NOT use re	ne during most of w	-		f Business/Ind	•
Maryland 21	uld be filed fental Hygir rked other tlc event, II	To Be Co	17. Father's Name (		en	1		18. Mother's Na	ame (First, Middle ZLNE 1			
	id 2 s lith ar 27 is 1 trau			me/Relationship (Typ				seechfie	_			
timore,	Pages 1 ar ment of Hea ant: If Item ary or other			osition  Cremation 3 Re County (Specify)	moval from State		Disposition (Name of crematory or other Memoria)	place) (Parly Feb	Date 6, 2004		on - City or To Hombre	
Balt	permit. Page Department of Important: if any injury of			neud a.		~	Ronald 108 L	dress of Eacility N. North	Son Fur Ave. B	neral aetin	Home	201
68760,	Physician and Medical Physician and Physicia	sal Examiner	23a. Part1. Enter the shock, or hara Immediate Cause (I disease or condition resulting in death)  Sequentially list configure, reading or many, reading or many, reading or many. Enter Under Cause (Disease or that initiated events resulting in death) L	ditions, b.	Due to (or as a		iano ()	dying, such as cardi		rrest,		Approximate Interval Between Onset and Death
O. Box	ne death certif the attending thed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	nonths?	ic. If yes, outcome of 1 Urive birth 2 4 Pregnant at ti 9 Unknown	Fetal death	3 □Ectopic pregn. 5 □ Other (specif)			23d.	Date of delive Month	ery Day Year
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f Vita	Physician: Th rthis certificate ral director, pag	To Be	25. Was case referrexaminer?	u.	ospital: 1 🗌 Inpatien	2 X ER/Outp	patient 3 DOA	Other	eath <i>(Check only</i> Home 5☐ Res	dence 6 🗆		<b>'y</b> )
Division o	Attending death. ictor: After	Certification;	27. Manner of Death  1  Natural  2  Accident  3  Suicide  4  Homicide	5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day) 200 2-1 28e. Place of Injury building, etc.	v · At home, farr	ury	Injury at Work? 1 □ Yes 2 No	28d. Describe Subset 28f. Location ( City or To	cr wi	2 2	al Route Number, MD
۵	Hospitel or / 124 hours after     Funerel Dire letely filled in b	edical Cer		1 Certifying Phys 2 Medical Examin	icien: To the best of	my knowledge, examination and		ne time, date and pla	ce, and due to the	cause(s) and	manner as s	
<b>)</b>	To the within 2. To the complet	Med	29b. Signature and	title of certifier	and manner state	eu.		cense number			gned (Month,	
	B		MARGAR		mpleted cause of de			l Penn Str	ceet, Bal	timore.	, Mary	land 21201
	Sta Regist		31. Date filed (Mon	EB 0 5 200	32 Registrar	's Signature	Garle.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 8.30 PM Parrish Frances Starr FEBRUARY, 1, 200 /Medical 4a. Fecility Name (If not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A8. Date of Birth (Month, Day, Year)
Dec. 27,1913 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛱 F 90 254-42-6154 Yrs. Director Georgia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at YyYes 2 □ No Baltimore Funeral Director N/AMaryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 W. 40th Street Apt. 255 21211-2170 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after Hyglene. l □Yes 2√Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Educator/Teacher Education unknown other other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event, 0003. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Barron Starr Margarete Newsome 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Margarete Parrish Warwick 4100 N. Charles Street Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore-Washington 2/6/2004 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Laurel, Maryland Crematory

22. Name and Address of Facility
Burger-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211 21. Signature of Euneral Service Licensee Mari 11. Enter the dis as or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASPIRATION PNEVIMONIA DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CEREBROVASCULAR Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events attending physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy in the past 12 months Month Year Day 5 Other (specify) 4 Pregnant at time of death Yes 2 10 9☐ Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Yes 2 No 3 Probably 4 Winkhown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? After this certificate 1□ Yes 2 1No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Hopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) dire 1 ☐ Yes \_ 2 ☐ No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending 1- Natural Injury investigation 1 Tes 2 No 2 Accident death the Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗋 Homicide To the Hospital within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) FEBRUARY. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital Puthumana 32. Registrar's agnature Juseph voins 31. Date filed (Month, Day, Year) State 5 200 Registrar

ORIGINAL

			Please   1 - For State Registrar		ryland / Dep. <i>Ce</i>		Health and	Mental Hy	giene	ble. N.L. N3297
	Physici		Decedent's Name (First, Middle, Last     Lester Howar				Douir	2. Date of Dea Month Februa	Day	3. Time of Death 10:35 P M
	/Medic Examir		4a. Facility Name (If not institution, give Renaissance Garde			4b. City, Town, Catonsv	or Location of Deat		4c. County	of Death
. W	Funeral Director		5. Social Security Number 6. Sec. 217-03-9019	x 7. Age	(In yrs. last birthday) 95 Yrs.	1	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Day APR 8,	h	9. Birthplace (State or Foreign Country) Maryland
	Aaryland f ehow	ō	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimon	<b>~</b> e	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3s or 28s-	Il Director	10e. Street and Number 707 Maiden Choice		Caroniova	10f. Zip Code 21228		1	10g. Citizen of W	
980	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ehow ont, the Madical Examiner must be multied at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 No. If Yes, Give Year or Dates:	0	Was Decedent of Hif Yes, specify Cub	dispanic Origin? (S an, Mexican, Puerl Specify:			- American Indian, k, White, etc. White
215-0	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)	cation e <i>completed)</i> College (1-4or 5-	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of word d)	rking	16b. Kind of Bu	siness/Industry
Maryland 21215-0036	d be filed wil	To Be Con	17. Father's Name (First, Middle, Last) Willard H. Palmer	4	U.S.	Governme	18. Mother's Nar	me (First, Middle, . Smith		n Service
	and 2 should ealth and Men n 27 is marke ier traumatic	ř	19a. Informant's Name/Relationship (Ty Carol L. Rigg/Daug			ng Address (Street Rockflee	and Number or Ru	ıral Route Numbe	r, City or Town, s	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itsms 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		Metro Cre	matory or other place ematory I	nc. 2-4		20c. Location - 0 Baltimo	ore, MD
Ba	Depar Impo		1)/	egorchik			rick Roa	d Balt	Inc. imore, M	1D 21228
١,	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	1	she death. Do not ent		ng, such as cardiac	or respiratory are	rest,	Approximate Interval Between Onset and Death
-	Ite be executed iysician and ne burial-transit	Ical Examiner	Sequentially list conditions, if a a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. =	consequence of):					
.O. Box 68	The law requires that the death certificate ite has been signed by the attending physioage 2 should be detached for use as the t	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	☐ Fetal death 3 ☐	Ectopic pregnancy	,		23d. Date Mont	of delivery th Day Year
rds, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions cor	itributing to death but	not resulting in the u	nderlying cause giv	en in Part I.			oute to the cause of death?
		Completed						24a. Was a autops perform	y pr ned? de	ere autopsy findings available ior to completion of cause of lath?
OT VIE	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☒ No	ospital:	2 DER/Outpatien	it 3 DOA Oth		th <i>(Check only on</i> ome 5 ☐ Reside		(Specify)
5	ding After	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Worl		28d. Describe ho		
2	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	building, etc.				City or Town	n, State)	r or Rural Route Number,
	the Hosp in 24 ho the Fune ipletely f	edical		ician: To the best of ter: On the basis of e and manner state	xamination and/or inv	occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the carred at the time, d	ause(s) and man ate and place, ar	ner as stated. ad due to the cause(s)
	VQ 6 7 ₹ 7	Σ	29b. Signature and title of certifier	V~D		29c. License	1.15	1	_	(Month, Day, Year)
_	7		30 Name an oddress person wro(co	JU W	an ch		no C	ghosu	16 V	Ven
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar	s Signature					

		1	For State Registrar	State of Maryl		artment of rtificate of		and Mo		giene leg. No. 2	004	03298
4	Physici	an	1. Decedent's Name (First, Middle, La  Ants Politina						2. Date of Dea Month	Day	2004	3. Time of Death 06:55 AM
	/Medio	-	4a. Facility Name (If not institution, giv			4b. City, Town,	or Location of	of Death		4c. Cou	nty of Death	
			Union Memorial  5 Social Security Number 6.8		yrs. last birthday)	Balt If Under 1 Year	imore		8. Date of Birth	n/a		place (State or Foreign
	Funeral Director			X M 2 □ F 63	Yrs. last billinday)	Months Days		Min.	(Month, Day May 21.	, Year)	Coul	tonia
	Q.	⊢	Usuel Residence of Decedent  10a. State 10b. County		. City, Town or Lo	ocation						10d. Inside City Limits
	daryla f ehov		MD Baltimo		Baltimo							1 ☐ Yes 2 No
	r 28a-	Funeral Director	10e. Street and Number		DOT OTHE	10f. Zip Code			· · · · · · · · · · · · · · · · · · ·	10g. Citizen	of What Cou	ntry?
	23a o	ralD	9010 Scotts Have			21 234					ed Sta	
	itams Itams	nue	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Ori ban, Mexican	gin? (Spe 1, Puerto F	orly Yes or No- Rican, etc.)		lace - Ameri llack, White,	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow the M. ofcel Exemiter must be notified at	۵	3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1□ Yes 2♥ No	Specify:			Spe	<sup>city:</sup> Whi	ite 
5-0	natur	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e durina mos.	t of workir	ng		Business/Inmore (	
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b	al Hyg	Be C	17. Father's Name (First, Middle, Last	)					(First, Middle,			
Maryland	ouid to	2	Voldemar Po	oldmae	10h Maili	ng Address (Stree						n Codel
Ma	nd 2 st lith and 27 is n r traun		Marju Poldmae/wi			Scotts				imore.		21234
re,	of Heal		20a. Method of Disposition	20	Ob. Place of Dispo	osition (Name of matory or other pi	ace)	D	ate	20c. Locatio	n - City or T	own, Stete
E	Page rrent ant: H		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Co	y) <u>[</u>	Moreland				/2004		ville	
Baltimore,	per it. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Der artment of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or itams 23a or 28a-1 show en; injury or other traumatic event, the Musical Examiner must be notified at one.		21. Signature of Funeral Service Xice		1	2. Name and Add	k Road	Τοι	wson, M	arylar		Home, Inc. 34
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not en	ter the mode of dy	ying, such as	cardiac o	r respiratory ari	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Myocardial		tion					-	26 days
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8760,	cate be ohysicia the bur	Ical	(	d								
Box 68	death certifica e attending ph id for use as tl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		<b>7</b>				23d.	Date of deliv	өгу
.O.	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		□Ectopic pregnar □ Other (specify)					Month	Day Year
Ω.,	uires that I signed by d be deta	y Ph	Part II. Other significant conditions	contributing to death but no	t resulting in the u	underlying cause of	given in Part I	l.	23e. Did to	bacco use c	_	the cause of death?
ord	v require been sig should b									′es 2□No	.,	
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Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_	ther		(Check only o			
of	Phys this ral dii	lon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time of Injury	of 28c. In	4 1140	2	ne 5 🗌 Resid 28d. Describe h			fy)
Division	or Atten ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not to determined	99 Place of Injune	At home, farm, st pecify)	reet, factory, offic	8	1	28f. Location (S City or Tow		mber or Run	al Route Number,
	Hospital     24 hours a     Funeral letely filled	edical C	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my miner: On the basis of exa and manner stated.	y knowledge, dea mination and/or in	th occurred at the nvestigation, in my	lime, date ar opinion, dea	nd place, a ath occurre	and due to the ded at the time.	cause(s) and date and plac	manner as s	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	)		-	nse number	, -		29d. Date sig		
)	10.7		Mittythan flow	-MD			43 8941	b - BZ	2	Februa	ry 3,	2004
5	1/		30. Name and address of person who Christopher You, 7		sity fark	way, Balt	imore, 1	up z	1218			
ĺ	St Regist	ate rar	31. Date filed (Month, Day, Year)	0 5 200 Registrar's	Signature	4 Asses						

04-0 AKG	803		For Amended Item 1 - State Registr Unpended Ite	1 State o	f Maryla	and / Depa	artment of h	Health a		ntal Hy	giene	004	03200
			Registratipe Lee     Regi		a-I,Per	ME, G8/28	32/48/04eg	Dealii	2.	Date of De		707	3. Time of Death
	Physici /Medio			Eric	Shawn	Picket	t, Sr.			Month Janu	Day Dary 29	Year 2007	9:01 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, o	or Location o	of Death			y of Death	
0.0			Franklin Squar				Rosedal		Od Han I -		Balti	more	County
(4)	Funeral Director		5. Social Security Number 215-90-2287	6. Sex 1 🕶 M 2 🗆 F	7. Age (In yi	s. last birthday) Yrs.	Il Under 1 Year Months Days	If Under : Hours	Min.	Month, Da	th y, Year) 19,1973	9. Birth	plece (State or Foreign intry) Vland
M			Usual Residence of Decedent						12.11	P 1 1 1	23/13/13	1101	yrana
	how		10a. State 10b. County		10c. (	City, Town or Lo	ocation						10d. Inside City Limits
	Ba-f e	Directo	4	altimore (	Co.			D	undall	k	-		1 ☐ Yes 2 ☐ No
	with the page 2		10e. Street and Number	on d			10f. Zip Code	212	24		10g. Citizen of		<sub>ntry?</sub> tates
	leath	Funerai	7410 Kirtley F		edent Ever in	U.S. 13.	Was Decedent of H			v Yes or No			can Indian.
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  In marked other then "naturel", or Iteme 23a or 28a-1 show aumstic event, the Medical Examiner must be notified at		1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed Fo	orces?		Was Decedent of HII Yes, specify Cubin 1 ☐ Yes 2 ☑ No		, Puerto Ric	ean, etc.)	Speci	ack, White,	
2-0	72 ho	Completed by	15. Decedent (Specify only highes	's Education		16a, Dece	dent's Usual Occup	oation during most	t of working		16b. Kind of E	3usiness/Ir	ndustry
21	Aithin hen	mpie	Elementary/Secondary (0-12)	College (	1-4or 5+)		kind of work done DO NOT use retired				United		
2	filed v Hygie other t	S	12 Years 17. Father's Name (First, Middle, 1	(ast)		M	ilitary /			irst Middle	Govern  Maiden Suma		
and	d be d ental l	To Be	Jackie Pickett							Baldwi		110)	
ary	s 1 and 2 should f Health and Men Item 27 le marke other traumatic	۲	19a. Informant's Name/Relations	nip <i>(Туре, Print)</i> В:	rother	19b. Maili	ng Address (Street	and Numbe	r or Rural R	oute Numbe	er, City or Town	, State, Zij	o Code)
Ž	of Health a		Mr. Jackie W. I	Pickett,	Jr.	74:	10 Kirtle	v Roa	d Dui	ndalk,	Marvla	and	21224
Baltimore, Maryland 21215-0036	t. Page: rtment o rtant: If rjury or		20a. Method of Disposition  1 ♣ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)		State	cemetery, crei	esition (Name of matory or other place V.A.		Date 2/9/20		20c. Location	-	
Balti	permit. Departrimports any inju		21. Signature of Funeral Service I	icensee		Di 79	Name and Addre uda-Ruck 922 Wise	ss of Facility Funer Ave	al Hor Dunda	me of	Dundall Jaryland	t, Inc	c. 222
	3/4		23a Part1. Enter the disease, or shock, or heart failer. List	complications that conly one cause on e	aused the de	ath. Do not ent	er the mode of dyir	ng, such as	cardiac or re	espiratory ai	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			oxication		, h . 199					Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a cons	equence of):							
- 1		7	Sequentially list conditions,	b. Due to	or as a cons	w uence of							
	ate be executed hysicien and the burial-transit	mine	Sequentially list conditions, it may lead to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	N. III	40. 40 4 00119	cale a rice of p							
ć		Examiner	resulting in death) Last	c. Due to	(or as a cons	equence of):							
760,	te be ysicie ne bur	cai		d									
89	ntifica ng ph	Medi	IF FEMALE:										
Division of Vital Records, P.O. Box	The law requires that the death certifica Ite has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		ointh 2 ☐ Fe nant at time ol	etal death 3	Ectopic pregnancy Other (specify)	<b>y</b>				ate of delive onth	ery Day Year
ırds, P	w requires that been signed b should be deta	by	Part II. Other significant condition	ns contributing to d	eath but not re	esulting in the u	nderlying cause giv	ren in Part I.			obacco use con /es 2 \( \text{No} \)	tribute to th	he cause of death? pably 4 Onknown
II Reco		Completed			<u> </u>					24a. Was autop perfores	sv	Were auto prior to co death? 1 Dayes	opsy findings available impletion of cause of
Vita	sician: Th certificate rector. pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death (C	Heck only o	ne)	1	
to	Phys r this ral dir	7	1. Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time of	-	4 Nur	SOFT WAY		dence 6 Ott		(y)
on	ding P th. : After i	tion	1 Natural 5 Pending 2 Accident investig	For (Mon	th, Day Year)	8:29	Wor	k?" Yes 2.2 <b>2</b> 0∩		known	iow injury occur	160	
VIS:	Atten r dea ector	ifica	3 Suicide 6 Could n	1/27/0			eet, factory, office	2010	_	Location (S	Street and Numi	ber or Rura	al Route Number,
Ö	s afte et Dir	Certification:	4 🖸 Homicide	found	in hote	L room			E	I Rich	Hotel, 82	13 Pul	laski Highway
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Exeminer: On the b and man	best of my k asis of exami ner stated.	nowledge, deatl nation and/or in	h occurred at the tir vestigation, in my o	me, date and pinion, deat	d place, and	alt bear due to the d at the time, d	rause(s) and m	anner as si and due to	tated. o the cause(s)
	To the h within 2 To the R complete	Σ	29b. Signature and title of certifler	111			29c. Licens				29d. Date signe	d (Month,	Day, Year)
			1. headar	4/6	×	w)	1	.M.E.		i	January	30,	2004
			30. Name and address of person v		se of death (It	em 23a) (Type,							
	⊚ Sta	to	31. Date liled (Month, Day, Year)	Miking 32/F	legiştrar's Sig	nature -	111 Per	nn Str	ceet.	Baltin	nore, M	aryla	nd 21201
	Sta Registr		FEB 0		Janear.		Span	1.1					
	MILATE AND	206	12000	1		1	7	AL TON					

_			1 - For State Registrar	State of Man		artment of I		_	giene Reg. No. 200	4 03300
	Physic /Medi	cal		Lewis Riley		1		2. Date of Dea Month Februa	ry 3, 2004	
	Examir	ner	4a. Facility Name (If not institution, give Hospice of the Ch	esapeake		Linth				ndel County
	Funeral Director		5. Social Security Number 6. S 215-34-1551	M 2□F	n yrs. last birthday, 65 Yrs.	Months Days		Month, Da	9. B y, Year) 29, 1938 M	irthplace (State or Foreign Country) aryland
	he Maryland Ba-f show diffed at	ctor	10a. State 10b. County Maryland Anne Ar		Glen Bu					10d. Inside City Limits 1 ☐ Yes 2 No
	h with th	ai Dire	10e. Street and Number 8049 Greenleaf Te	rrace Apt.	13	10f. Zip Code	21	060	10g. Citizen of What C	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel" or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam are must be multied at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married ※※※ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1 9 5		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2√MNo		Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
1215-0	within 72 ho ane. than "natur is Medical J	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup e kind of work done DO NOT use retire chouse Su	during most of wo d)	rking	16b. Kind of Busines	,
rland 2	uld be filed v Mental Hygie irked other t itic event, tt	To Be Co	12 17. Father's Name (First, Middle, Last) Lewis A. Riley		wale	enouse su	18. Mother's Na	me (First, Middle, n Leona F	Maiden Sumame)	Anufacturing
Baltimore, Maryland 21215-0036	1 and 2 short Health and New 27 is mather trauma		19a. Informant's Name/Relationship (Mrs. Sandra Riley 20a. Method of Disposition	(Wife)	8049	Greenlea:	f Terrace			ie, MD 21060
altimor	mit. Pages bartment of sortant: If it injury or o		1 ☐ Burial 2 【 Thermation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service ≰icep	r)   I	Baltimore	osition (Name of matory or other place—Washing	ton $\frac{1}{2}$	/200/	Laurel, Ma	ryland
ä	Depa Impo any i		Kary 4	arpenter	Bu 36	rgee-Hens 31 Falls	ss-Seitz Road I	Funeral Baltimore	Home, Inc.	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or compshock, or heart diffure. List only immediate Cause (Final disease or condition resulting in death)	aDue to (or as a co	etatu	to Bri	tale	Care	,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	ical Examiner	Sequentially list conditions, it any, leading to infiltediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a co						
P.O. Box 68	ath certil ttending or use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy	/		23d. Date of de Month	Divery Day Year
	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t es 2 No 3 □ P	o the cause of death?
Vital Records,	ysician: The law re is certificate has be director, page 2 sh	Completed						24a. Was a autops perfori	prior to	utopsy findings available completion of cause of
	ysician: Th s certificate director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 ☐ ER/Outpatier	nt 3□ DOA Oth		th (Check only on	ence 6 DOther (Spe	mail la Dice.
Division of	ttending Physideath. ctor: After this the funeral di	Certification: T	27. Manne of Death  112 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		f 28c. Injun Worl	y at		ow injury occurred	KIII) TOTAL
Ö	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		3 Suicide 6 Could not be determined	building, etc. (S)	pecify)			City or Town		
	the Hos nin 24 ho nhe Fun npletely (	Medical	(Check only one)	ysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, death imination and/or in-	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the carried at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
)	To To	2	29b. Signature and title of certifier	(li Oc	11	29c. Licens	e number	) <sup>2</sup>	9d. Date signed (Mont	th, Day, Year) 42004
	V		30. Name and address of person with a state of the state	De Lives D.C.	). 301	Hospi	Jal D	Sine C	Hensym	m/2/06/
	Sta Registr		EED 0.5	32. Register's S	Signature	Locales		1		a 8

			For State	State of Ma	ıryland			of Health a of Death				004	0330	Military and American
			Registrar  1. Decedent's Name (First, Middle, Last	)	-	007	inouto	or Douter		2. Date of Dea	th		3. Time of Death	-
П	Physicia			Anthony	Rub	eling	2			Februar	$y \stackrel{\text{Day}}{3}, 20$	OO4	5:17 PM	
	/Medic Examin		4a. Facility Name (If not institution, give					wn, or Location of				ity of Death	, , , , ,	_
	L. Admini	Ŭ.	Johns Hopkins	Bayview	Medio	cal Ct	r. :	Baltim	ore			N	/ A	
	Funeral		5. Social Security Number 6. Se			st birthday)	If Under 1 Y	ear If Under ays Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) DEC 15	, Year)	9. Birthp	lace (State or Foreign	
il) e	Director	]	210-34-1703 2	ŽM 2□ F	65	Yrs.				DEC 15	, 1938		yland	_
	and	}	Usuel Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation					1	0d. Inside City Limits	
	Maryl f sho	ō	Maryland Balti	more			Ra1	timore					1 ☐ Yes 2 X No	
	28a	Director	10e. Street and Number	ino i c			10f. Zip Co				10g. Citizen o	of What Cour	ntry?	-
	h with		7235 Hughes A	venue			21	219		-		USA		
	deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	i. 13. V	Vas Decedent	t of Hispanic Ori Cuban, Mexicar	igin? (Spe	ecify Yes or No-		ace - Americ		
9	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or items 23a or 28a-f show ent, the Medical Exams her must be notified at	F	1 Never Married 2 Married	1 ☐ Yes 2 🔯 N If Yes, Give	lo		☐ Yes 2X				Spec		ite	
Ö	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	1	10- D1	ent's Usual C							_
5	n 72 nat	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		(Give I		lone durina mos	t of worki	ng .	16b. Kind of	Dusiness/in	dustry	
12	with iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5	+) I	Home In	mprove	ment Co	ntra	ctor	Home :	Improv	ement	
ğ	i Hyg othe	Bec	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,	Maiden Sumi	ame)		
<u> a</u>	should be and Mental marked of umatic eve	To E	George Rubelin	.g				Ma	rie	Prell	er			
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mantal Hygiene.  If file m 27 is marked other than "natural", or items 23a or 28a-f show it if item 27 is marked other than "natural", or items 2 is marked other than "natural Examalisa" must be notified at or other treumatic event, the Martical Examalisa must be notified at		19a. Informant's Name/Relationship (7)	vpe, Print)		19b. Mailin	g Address (S	treet and Numbe	er or Rura	l Route Numbe	r, City or Tow	m, State, Zip	Code)	
	and eaith m 27 ner tr		Lucy M. Rubelin	g/Wife	agt. Dt.			es Ave						_
ore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	Removal from State	Cei	metery, crem	sition (Name i atory or othe	r place)		ate	20c. Location			
timore,	tmen tant:		'4 □Donation 5 □Other (Specify)		Meti			, Inc.			Balt:		, MD	_
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other ance.		21. Signature of Juneral Service Mons	nul	_			Ion Sol					D 01000	
			23a. Part1. Enter the disease or comp	égorchil	the death.							re, M	D 21228 Approximate	
			shock, or heart failure. List only o	ne cause on each lin	Θ.	. 1.		(Construction		,	,		Interval Between Onset and Death	
8.	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	conseque	ence of):	in	rage					Openute	_
W	Examiner			Recu	nen	t 54	zi am	ous ce	ll ca	ucen 1	mouth	amir	4 martis	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	ence of):					N /	0		
	nd ransi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c										
90,	cate be executed physicien and the burial-transit	i Ex	resulting in death) Last	Due to (or as	a conseque	ence of):								
8760	physic the t	dicai		d						·				_
9 X	death certifica attending ph d for use as t	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	icy				_	234 [	Date of delive	NDV	
Вох	that the death cert ed by the attendin detached for use	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pregr Other (special					Month	Day Year	
o.	t the d	hysi	9 Unknown	9□ Unknown										
S, D	signed I	by Physician/Med	Part II. Other significant conditions co			-		-		23e. Did to	bacco use co	ontribute to th	e cause of death?	
ğ	w require been sig should b	ed	beatmen fra	n chem	other	exp				1 🗗	es 2 No	3 🗌 Prob	ably 4 □Unknown	
ecc	law re as be 2 she	ple	History of or	worn La	PTC	ROPH	Any	1		24a. Was autop		. Were auto	psy findings available ripletion of cause of	
<u> </u>	The ate h page	Completed	·							perfor	med? 2 € No	death?		
Vital Record	ysicien: The lar is certificate has director, page 2	Be	25. Was case referred to medical examiner?	Hospital:					of Death	(Check only o	ne)		11) - Niber - 1111	
	Physithis caldir	-T	1 Yes 2 No  27. Manner of Death	1 L Inpatie		R/Outpatient 28b. Time of	-	Other: 4 Nu	-	me 5 Resid			()	
no	ding F h. After funer	tion	1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)	Year)	Injury	м	Work? 1 ☐ Yes 2 ☐		EDG. Describe I	OW INJURY OCC	D11-60		
Division of	or Attendi after death. Director: A in by the fu	fica	3 Suicide 6 Could not be	28e. Place of Inju	ıry - At hon	ne, farm, stre						n <i>ber or Rur</i> a	l Route Number,	_
5	el or A s after il Dire	Certification;	4  Homicide	building, etc	:. (Specify)					City or Tow	n, State)			
	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical (	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of	of my know examination	rledge, death on and/or inv	occurred at t	he time, date an	nd place, a	and due to the d	ause(s) and r	manner as si	ated.	-
	To the F within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner sta	ted.			cense number			29d. Date sign			
)	7. w 7.00		We will be	O. in	2		_	28133	3		_			
	10	1	30. Name and address of person who c	ompleted cause of d	eath (Item	23a) (Tuna 1	' /	-01)		1	eorua	ry 4	, 2004	
	V				#20	50 B1	AUTIN	40 Mg	MI.	2/20	4			
yth.	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signati		111							
	Registr	ar	FFR 0 5 2004	E STORES OF THE	and the same	TO CARL	P							

			1 - For State Registrar	State o	of Maryla	•	artmen rtificate			ind M	ental Hyg	iene	2004	03302
	Physici		1. Decedent's Name (First, Middle, Las	Paul	Jar	mes	Remle	ein			2. Date of Dea Month Februa	Day		3. Time of Death 5:00 A <sup>M</sup>
)	/Medic Examin		4a. Facility Name (If not institution, give	_	mber)		4b. City,	Town, or	Location of	f Death	reprua	4c. (	County of Deat	h
	Francis		1010 Bear Pond Ro  5. Social Security Number 6. Se		7. Age (In yr	s. last birthday	Te		eville If Under 2		8. Date of Birth			nne's Co.
	Funeral Director		219-50-3173	-χM 2□F	55	Yrs.	Months	Days	Hours	Min.	(Month, Day Feb. 4		Co	untry) :yland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. (	City, Town or L	ocation		-					10d. Inside City Limits
	e Many Ra-f sh	ctor	Maryland Queen A	nne's				Te	emple	vill	e			1 ☐ Yes 2√ € No
	with th	Director	10e. Street and Number 1010 Bear Pond R	oad			10f. Zip	Code	21	670	1	-	zen of What Co Lited St	•
	death	Funeral	11. Marital Status		edent Ever in	U.S. 13.	Was Deced	lent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	1	4. Race - Ame Black, White	
36	d within 72 hours after death with the Maryland jiene. I then "natural", or Items 23a or 28a-f show The Medical Examine thust be molified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes If Yes Gi	2 🗌 No		1 ☐ Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,			Specify:	White
Maryland 21215-0036	72 hou natura lical E		15. Decedent's Ed (Specify only highest grad	ucation		16a. Dece	dent's Usua kind of wor	I Occupa	tion	of workii	na	16b. Kin	nd of Business/	ndustry
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (		life.	DO NOT us	e retired)				α.	1+ M-	4-1
nd 2	Hyg othe	Be Co	12 Years 17. Father's Name (First, Middle, Last)			snee	t Meta				(First, Middle,		heet Me Sumame)	CdI
ylaı	2 should be and Mental is marked o	To	Jacob James Rem			405 14-11	4 4 4	(011-			Jane Fe			
	is 1 and 2 should of Health and Men Item 27 is marks other traumatic		Mrs. Carla Lee R	•	(Wife)		ng Address D Bear				<i>l Route Number</i> <b>Femplev:</b>	-		and 21670
Baltimore,	Pages 1 a nent of Hea int: If Item iry or othe	100	20a. Method of Disposition 12 Burial 2 □ Cremation 3 □		20b	. Place of Disp cemetery, cre	osition (Nan matory or of	ne of ther place	)	D	ate	20c. Loc	cation - City or	Town, State
Iţim	그 돈 말 금		* 4 □ Donation 5 □ Other (Specify 21. Signature) of Funeral Service Licen	)		Crownsv	ille V 2. Name an				/2004	Cr	ownsvil	le, MD
Ba	Departing Port		deshanie	Ma	sser	ND.	ıda-Ru	ick F	unera	al Ho	ome of I	ound vlai	alk, In	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	olications that one cause on	caused the de each line.		ter the mode	e of dying	, such as o	cardiac o	r respiratory arr			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Muld	gfate (or as a cons	equence of):	ller	C	arre	non	rec			
	Examiner		Sequentially list conditions.	b										
T	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a cons	equence of):								
, 0,	sate be executed thysician and the burial-transit		resulting in death) Last	Due to	(or as a cons	equence of):								
68760,	ficate b physic s the b	Physician/Medical		d	·									
Вох	death certificate e attending phys id for use as the	an/M	23b. Was decedent pregnant	23c. If yes, ou 1□Live I	tcome of preg		∃Ectopic pre	egnancy				2	3d. Date of deli	•
0.	that the dea ned by the at detached fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregr 9□ Unkn	nant at time of own		Other (spe						Month	Day Year
o,	res that the igned by th be detache	by Ph	Part II. Other significant conditions co	ontributing to d	eath but not r	esulting in the t	inderlying ca	ause give	n in Part I.		23e. Did to	acco us	se contribute to	the cause of death?
ord	law requires as been sign 2 should be				·						1 🗆 Ye	s 2 [	No 3□Pro	bably 4 Unknown
Vital Records,	0 - 0	ompleted									24a. Was a autops perforr	y ned?	prior to death?	opsy findings available ompletion of cause of
ital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	1 ☐ Yes 2		1 🗆 Yes	2 □ No
of V	Phys this ral dii	2	1 Yes 2 No.	Hospital: 1   28a. Date		ER/Outpatie		-	4 🗀 Nur	-	ne 5 Mescribe ho			ify)
ion	Attending I ir death. ector: After by the funer	atlon	1 Natural 5 Pending 2 Accident investigation	(Mon	nth, Day Year)	Injury	М	8c. Injury Work 1 □ Y	?` ′es 2 □ N				00001100	
Division	al or Attend after death Director: , d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	289. Place	of Injury - At ing, etc. (Spe	home, farm, st	reet, factory	office		2	8f. Location (St City or Town		Number or Ru	ral Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	a Ce	29a. Certifier 1 Certifying Ph	ysician: To the	e best of my k	nowledge, dear	h occurred a	at the time	e, date and	d place, a	and due to the ca	tuse(s) a	and manner as	stated.
	To the Ho within 24 To the Fu completel	Medical	(Check only 2 Medicel Exemone)  29b. Signature and title of certifier	imer: On the b	nasis of exami iner stated.	nation and/or in	vestigation,	in my op	inion, death	h occurre	ed at the time, d	ate and p	place, and due	to the cause(s)
	To To Con		29b. Signature and title of certifier	mille.	. /.	MI				1 1 2			signed (Month	*
,	X		30. Name and address of person who d	completed caus	se of death (It	em 23a) (Type	Print)	1)	0	11	to m		1	
	Sta	te	1. Date filed (Month, Day, Year)	32. F	76 Registrar's Sig	フ <u> /</u> / / / / / / / / / / / / / / / / / /	GRAI	IKI	rel	SH	to No	۷.	2127	
	Registr			5 2004		المد ساهنا	1	ask .	}					

DHMH 17 Rev 1/2001

Registrar

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JANUARY

ANNA SLATER

**ORIGINAL** 

Registrar

FEB 0 5 2004

		·	1 - For State Registrar AMEND ITEM #11	State of Marylan					Reg. No	200	4 03305
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     N I LD RED      4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of	2. Date of Month	ARE C	County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 214-14-3818			If Under 1 Year Months Days	If Under 2 Hours		Birth (2007), 1919	9. Big	thplace (State or Foreign buntry) MD
	he Maryland 18e-f show culfed at	ector	Usual Residence of Decedent  10a. State  MD  BALTI		y, Town or Lo	NGS MILLS			10- 6:	inne of lather C	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 le marked other than "natural", or items 23a or 28e-f show important: If item 27 le marked other than "natural", or items 23a or 28e-f show any injury or other traumatic evant, Ira Medical Exactinar mail to notified at ances.	by Funeral Director	10e. Street and Number  2307 CAVESDALE RO  11. Marital Status  1 Never Married  322 Married  322 Microsed	AD  2. Was Decedent Ever in U. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba	2111 lispanic Origi an, Mexican, Specify:			14. Race - Ame Black, White Specify:	U.S.A.
21215-0036	d within 72 hou giene. er than "natura i Ir e Medical E.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired EMAKER	during most of	of working	16b. K	of Business	
Maryland	should be filed ind Mental Hygi markad other umatic evant, II	To Be	17. Father's Name (First, Middle, Last)  MORRIS  19a. Informant's Name/Relationship (Type	na Print)		LAEN	M]	S Name (First, Mid INNIE	F	FISHER	Zin Codel
	is 1 and 2 sho of Health and item 27 le m other traum		SUE SINGER / DAUG 20a. Method of Disposition	GHTER 206. P	2307	7 CAVESDA sition (Name of natory or other place	LE ROA		GS MII		21117
Baltimore,	permit. Pages 1 Department of the Important: If ite any injury or ot once.		1 🛱 Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	BAL	_TIMORI	E HEBREW	CEM. 2	SOL LEV	INSON	& BROS	
760	Physician /Medical Examiner	Ical Examiner	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line. <u>SEPS</u> Due to (or as a consequ	uence of):	er the mode of dyin				ESVILLE	Approximate Interval Between Onset and Death
P.O. Box 68	D 0 D	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 250 No 9 ☐ Unknown	ac. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3□	Ectopic pregnancy	,			23d. Date of de Month	livery Day Year
	law requires that the as been signed by th 2 should be detache	ed by Ph	Part II. Other significant conditions con CEREBROVASCUL		ulting in the ui のといて		en in Part I.		id tobacco u		o the cause of death?
al Records,	The ate h page	e Complet	25. Was case referred to medical				00.8	1□ Ye	utopsy erformed? s 2 No	prior to death?	utopsy findings available completion of cause of
Division of Vital	ding Phys h. After this funeral di	To B	examiner?  1  Yes 2  No H  27. Manner of Death 1  Natural 5  Pending 2  Accident investigation	ospital: 1 Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Worl	er: 4 🗆 Nurs				icity)
Divi	- 9 -	al Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify ician: To the best of my kno	v) wledge, death	n occurred at the tin	ne, date and	City or place, and due to	Town, State	and manner as	ural Route Number,
	To the Hospitel or within 24 hours aft To the Funerel Di completely filled in	Medical	(Check only 2 Medical Examinone)  29b. Signature and fitte of certifie	eer: On the basis of examina and manner stated.	tion and/or in	29c Licens	pinion, death	23.	ne, date and	I place, and due te signed (Mont RUARY	o to the cause(s)
	$\varphi$		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type, KISH	Print) NORTH	HWE	57 Hose -D Cour	TRE	L CE	NTER.
	Sta Registi		31. Date filed (Month, Day, Year) FFB 0 5	32. Registrar's Signa	ture	to do	On March 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State AMEND ITEM #19a PER INF G828 2/12/Qertificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day :5/ M **Physician** YEVSEY SHAPIRO ebruar 2004 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hrs. 8. Bate of Birth Min. DE Month, 3ay, LOF Baltimore N/A ta If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sax **Funeral 9**2 UKRATINE 212-33-1479 1 □ M 2 □ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at N/A BALTIMORE 1 X Yes 2 □ No MD. Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21215 6940 MARSUE DR. APT. 1-A Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗖 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0·12) College (1-4or 5+) FACTORY WORKER STEEL INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SHAPIRO (UNOBTAINABLE) ပ 19a. Informant's Name/Relationship (Type, Print) GRINBERG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS.SOFIYA SHAPIRO/WIFE 6940 MARSUE DRIVE APT. 1-A BALTIMORE.MD. Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 2/4/2004 ARLINGTON-CHIZUK AMUNO 5 permit. Page Department of Important: If ony injury or BALTIMORE, MD. \* 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 21. Signature of Funeral Service Licensee Edwani 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician day /Medical Due to (or as a consequence of) lar lymphoma **Examiner** 2112 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical the Division of Vital Records, P.O. Box 687 as attending IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Po in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death Yes 2 No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 2 D No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s autopsy performed? 210 No 210 No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 1 Inpatient ij 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type, Print)

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

KG			•	icasc	State of	f Maryland						-		e			
			1 - For Amend Registrar Unpe	Item	# 1	•						-	Reg. No	200	14	03	307
			1. Decedent's Name (First,	Middle, L	tem#238 ast)	a-D, Z/,	Per	ME,	828	, 3/4	/ U 4 (	2. Date of De	ath			3. Time o	of Death
	Physicia		Raymond		V	Santor	a	Jr.				Month	Da	y Y 28, 20	rear	8:24	<sub>A</sub> M
	/Medic Examin		4a. Fecility Name (If not ins	titution, gi	ve street and nur	nber)	•	4b. City,	Town, or	Location	of Death	Odirac		. County of		0.24	
	_xuiiii.	•	Anne Arunde	el Med	dical Ce	enter		Anna	mol:	is			1	Anne A	ARun	del	
1/2	Funeral		5. Social Security Number	6.	Sex	7. Age (In yrs. la				If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug 10	th v, Year)	) 9		lace (Stete try) York	or Foreign
N	Director		066-44-5192		1 M 2□F	36	Yrs.					Aug 10	, 19	967	New	<u>York</u>	
	pur *	}	Usual Residence of Deced	ent County		10c. City.	Town or L	ocation							10	Od. Inside C	City Limits
	faryla r sho	ō		•	rundel		Annapo										s 2 No
	28e-	rect	10e. Street and Number		- I Gilde I		шар	10f, Zip	Code			1	10g. Cit	tizen of Wh	at Coun'	try?	
	Sa or	<u> </u>	1215 Honeysu	ıck1e	Lane				2	1401			115	SA			
	ms 2:	Funeral Director	11. Marital Status		12. Was Dece	edent Ever in U.S	i. 13.	Was Dece			gin? (Sp	ecify Yes or No Rican, etc.)		14. Race -			
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121	within ne.	ш	Elementary/Secondary (	0-12)	College (1	1-4or 5+)		orney								Colu	mhia
2	Hygie Hygie Ther I	ပိ	17. Father's Name (First, N	diddle Las					1141		er's Name	e (First, Middle					
ano	d be	) Be	Raymond Sant		-7							chuster					
₹	Shoul Inari	2	19a. Informant's Name/Re	lationship	(Type, Print)		19b. Maili	ing Address	(Street a	and Numbe	er or Rura	al Route Numb	er, City o	or Town, St	ate, Zip	Code)	
<b>S</b>	nd 2 lith at 27 is r fret		Cassandra Wo	od-Sa	antora (	Wife)	12	215 Hc	nevs	suck1	e La	ne Anna	noli	is. MT	)		
ē	s 1 and 2 should be tiled within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other then "natural, or Items 23s or 28e-1 show other treumatic event, the Medical Examiner must be notified at		20a. Method of Disposition			20b. Pla		osition (Nar				Date		ocation - Ci		wn, State	
E	Pages nent of I ant: If Its ury or o		1 XBurial 2 ☐ Crem *4 ☐ Donati∮n 5 ☐ Ot			SIMILE		ılchre			2-5	-04	Cor	cam, N	lew :	York	
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		21. Signature of Funeral S	ervice Lice	ensee	. 00	2	2. Name an	d Addres	s of Facilit	ty for	Funeral					
<u> </u>	89 6 8 8		Mell	-1.0	Dode	West		45-09	Lit	tle l	Neck	Pkwy	Litt	le Ne	ck.	NY 1	1362
		1	23a. Par 1. Enter the diseast shock, or reart failure	ase, or e. List onl	mplications that c y one cause on e	aused the death. each line.	Do not en	ter the mod	le of dyin	g, such as	cardiac	or respiratory a	rrest,			Approximation	tween
	Physician		Immediate Cause (Final		a Coro	onary A	rter	v Th	tom	ne f						Onset and	Death
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CIT .	ted nsit	nlne	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events	°⊀	500.10	(or as a conseque	51100 01).										
XX	al-tra	Examiner	that initiated events resulting in death) Last		c. Due to (	(or as a conseque	ence of):								_		
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	titicat ig phy as th																
ŏ	eath cert attendin for use	N/VE	IF FEMALE: 23b. Was decedent pregna		23c. If yes, out	tcome of pregnan	cy death 3[	⊒Ectopic pr	egnancy					23d. Date		-	M.
Division of Vital Records, P.O. Box 68	the att	by Physician/Med	in the past 12 months 1 ☐ Yes 2 ☐ No	5?		ant at time of dea		Other (sp						Month	1 1	Day	Year
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Ś	signed b		Pan II. Other significant c	onemons	contributing to de	eath but not resur	ung m (ne i	ingerlying c	ause givi	en in Parti	•		Yes 2		Proba		Unknown
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<u></u>	ician: The t certificate ha rector, page				,			-				1 X Yes	2 🗆 No			2 🗆 No	
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/isi	Attendir death.	ifica	3 Suicide 6	Could not determine	be 28e. Place	of Injury - At hor		reet, factory	, office		Ť	28f. Location (			or Rural	Route Nun	nber,
Ď	s atter	Certification;	4  Homicide		- buildi	ing, etc. (Specity)						City or To	wn, State	θ)			
	To the Hospitel or Attending Physicien: The law requires that the death certitica within 24 hours atter death.  To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the				hysician: To the												e1
	in 24 he Fi pletel	Medical	one)			asis of examination ner stated.	on and/or ir				un occum	eu ai îne îime,					2)
	To t To t	Σ	29b. Signature and title of			20 -		290		number				ite signed (			
0	5		1 Zak	in	iah t	77			O.C.	.M.E.			Janu	uary 2	49,	2004	
05	PONDING		30. Name and address of p	erson who	completed caus	se of death (Item	23а) (Туре	,	1 D	on Ci					71.		20-
	- 000		31. Date filed (Month, Day	Year)	32 B	Registrar's Signati	ıre				r <b>e</b> et	, Balti	more	e, Mai	ryla	nd 21:	201
	Sta Registr		FFR 0		A	and in the	19	Spa	-	, -							
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ORIGINAL

				**	Indelible Ink. Ensure All epartment of Health and M	•	•	
		•	For State Registrar	_	Certificate of Death		No. 2004	03308
Ph	nysicia	an	1. Decedent's Name (First, Middle, L			2. Date of Death Month	Day Year	3. Time of Death
//	Medic	al	William Geo  4a. Facility Name (If not institution, gi	orge Sharpe	4b. City, Town, or Location of Death	February	4, 2004.	5:45 a <sup>M</sup>
E	kamin	er	Carroll Lutherar		Westminster		Carrol1	
Fur	neral			. Sex 7. Age (In yrs. last birthe		8. Date of Birth (Month, Day, Y		ace (State or Foreign try)
Dire	ector		026-10-0584 Usual Residence of Decedent	12KM 2□F 92 Yr		Dec. 15,		
riand	<b>a</b>		10a. State 10b. County	10c. City, Town	or Location		1	0d. Inside City Limits
a-feh	paili	ctor	MD Carro	o11	Westminster			1 ☐ Yes 2 ☒ No
dit th	gu eq	Funeral Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coun	·
eath v	Taunt	eral	250 St Lukes (		21158  13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	U.S.A	
after d	nlner		1 Never Married 2 Married	d 1⊠Yes 2 No	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White,	etc.
Designation (e.) Mary failed A. I.Z. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Innoctant: It item 27 is marked other than "natural", or items 23a or 28a-f ehow	Exa	d by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates: WWII				White
72 h	edica	Completed	15. Decedent's l (Specify only highest g	Education 16a. D grade completed)	Decedent's Usual Occupation Give kind of work done during most of workit life. DO NOT use retired)	ng 16	b. Kind of Business/Ind	lustry
d withii	M edi	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Manufacturer		Chemical (	Company
d be filed intal Hyg	vent.	BeC	17. Father's Name (First, Middle, Las	st)	18. Mother's Name	(First, Middle, Ma.		
Vicin build to Mentit	atic	To	William A.			W. Burne		
Vicil 12 sh h and 7 is m	raum	1 3	19a. Informant's Name/Relationship	04-5	Mailing Address (Street and Number or Rura			Code)
Healt	other	10	Etta Treuchet 20a. Method of Disposition	01		rstown, l	MD 21136 c. Location - City or To	wn, State
Pages ent of	ry or c		1 ☐ Burial 2 ☑ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	Linemoval from State	crematory or other place) 1 Cremation Ser 2/5/	04 Ha	impstead,	Maryland
Daritimor Department of mocrtant: If it	any enju once		21. Signature of Funeral Service Lic	ensee	22. Name and Address of Facility 118		(I 1550 )	Tr or architecture
0 85E	ā 8		fram (	& Cin	ELINE FUNERAL HOME			
		1	23a. Fart1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	in plications that caused the death. Do no ity one cause on each line.	of enter the mode of dying, such as cardiac o	r respiratory arrest	'	Approximate Interval Between Onset and Death
Physi /Med	ician dical	9	disease or condition resulting in death)	Due to (or as a consequence of				2 warks
Exam	niner		1	b	<i>p</i>			
ס	#	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of	):			
oU, be executed icien and	burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	):			
Sicien	buria	TO		d	•			
tificate	as the	Physician/Medic						
ath cer	or use	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delive	ry Day Year
De des	thed for	yslci	1 Yes 2 No	4□Pregnant at time of death 9□ Unknown	5 Other (specify)			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
that the	detac	y Ph	Part II. Other significant conditions	s contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
v requires	nid be	ed by	COPD			1 ☐ Yes	2 □ No 3 Prob	abiy 4 Unknown
law re	2 sho	Completed	CAD			24a. Was an autopsy		osy findings available inpletion of cause of
The	page	Com	CHF			performe	d? death?	2. No
VICAL ician:	ector,	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death			
Phys C	aral div	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. Tir	me of 28c. Injury at 2	ne 5 Residence 8d. Describe how	e 6 Other (Specify injury occurred	")
Attending or death.	e fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		ury Work? M 1 □ Yes 2 □ No			
VIS r Atte	by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	t be ed 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
Dital o	lled ir		on outlier a Vocation	Dhardein Talkabara Amalanda	dark and a second at the secon			
24 ho	etely	edica	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	caminer: On the basis of examination and/ and manner stated.	death occurred at the time, date and place, a for investigation, in my opinion, death occurred.	ed at the time, date	e and place, and due to	the cause(s)
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Fundral Director. Mint this certificate has been stoned by the atlanding bloos.	compl	₩ We	29b. Signature and title of certifier	1 -	29c. License number	29d	Date signed (Month, I	Day, Year)
2	X١		Breux	0,0.0.	4005584	15 a	14/04	
r	2		30. No e and address of person wh	no completed cause of death (Item 23a) (T	ype, Print)	E'S/	1 w	ESTMINST
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's/Signature	1	V 116	1	
R	egistr		FE8 0 5 2	1004 Server St. A	goods.			

			For State Registrar	State	of Mary		epartmen Certificate			and M	lental Hyg	jiene leg. No. (	2004	033	09
	Physici: /Medic		Decedent's Name (First, Middle	e, Last) He]	.en	J.	Scol	isky	•		2. Date of Dea Month Februar	Day	Year 2004	3. Time of D	
	Examin		4a. Fecility Name (If not institution			7			Location o			4c. C	ounty of Dear		
	F		Genesis Heritag  5. Social Security Number	e Meridia 6. Sex		dercare			Dunda If Under:		8. Date of Birth (Month, Day	1		imore	Foreian
	Funeral Director		233-52-6706	1□M 2뒀F	95	Yr	Months	Days	Hours	Min.	(Month, Day Dec. 2	, <i>Yeer)</i> , 1908	Co	ennsylvai	-
	pu k		Usual Residence of Decedent  10a. State 10b. County		10	c. City, Town o	or Location							10d. Inside City	Limits
	Maryla f sho	ō	Maryland	Baltimon		, ,			I	unda	alk			1 🗆 Yes 2	
	r 28a-	Directo	10e. Street and Number				10f. Zip	Code				l0g. Citize	n of What Co	ountry?	
	23a c	raiD	7617 Maple Road							1222		Uni	ted St	ates	
	er dez	Funeral	11. Marital Status	12. Was Dec	orces?	r in U.S.	13. Was Deced If Yes, spec	lent of Hi of Cuba	spanic Orio n, Mexican	gin? (Spe , Puerto l	ecify Yes or No- Rican, etc.)	14	. Race · Ame Black, Whit		
36	hours aft tural', or at Exami	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, G	2 [v] No ive Dates:		1☐Yes	20 No	Specify:			S	oecity: Wh	ite	
9500-612	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, it s Maulcal Examinar must be multified at	Completed	15. Deceden		)	16a. D	ecedent's Usua Give kind of wo	I Occupa	ition furing most	of worki	na	16b. Kind	of Business	Industry	
7	within ne. han "	mpie	Elementary/Secondary (0-12)	1	1-4or 5+)	` <i>li</i>	Give kind of world ife. DO NOT us		)				O TTo	m a	
Z 0	filed v Hygie other t	Co	7 Years 17. Father's Name (First, Middle,	Last)			Homema	ker	18. Mothe	r's Name	(First, Middle,		Own Ho (mame)	me	
	uid be fental rked c	To Be	Andrew Cherr	У					I	Mary	Manzanl	0			
<u>a</u>	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relations		1>						Route Number			Zip Code) Naryland	2110
_	s 1 and f Health item 27 other tr		Julie Damilosk  20a. Method of Disposition	i (Daugl			isposition (Nan		Anne				tion - City or		2110
פֿ			1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (S		I .	cemetery,	crematory or o p Servi	ther place	1					Maryland	a
	P. Inite	i	21. Signature of Funeral Service		) (	)					4/2004 Home of				_
ñ	Den Impo		regon	2/6	es		7922	Wise	Ave.	Du	ndalk,	Mary	land	21222	
750	physician and purial-transit sthe burial-transit	dicai Examiner	23a. Part1. Enter the disease, of shock, or hear failure. List Immediate Cause (Final disease or con mon resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b. Due to c. Due to	each line.	1	TONAK	Y e BE	ARK. DOD	Es	/NFB)		-10N	Approximate Interval Betwe Onset and De	en nath
O. Box 6	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 🗌 nant at time	Fetal death	3 ☐Ectopic pr 5 ☐ Other (sp					230	d. Date of del Month	ivery Day Ye	ıar
ds, P	w requires that been signed b should be deta	þ	Part II. Other significant condition	ons contributing to	death but no	ot resulting in th	ne underlying c	ause give	n in Part I.			bacco use es 2□i		the cause of dea	
	The la ate has page 2	Completed		>-						_	24a. Was a autops perform	n : y med? 2 <b>X</b> No	24b. Were au prior to d death? 1 🗌 Yes	topsy findings av completion of cau	railable use of
Vital	Physicien: 7 r this certificat ral director, p	) Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient	2   EB/Oute	atient 3 DO	Othe			(Check only on me 5 ☐ Reside		7045 /0	-4.1	
	g Phys er this eral di	n: To	27. Manner of Death	28a. Date	of Injury		ne of 2	Bc. Injury Work	at	_	28d. Describe h			any)	
0	Attending F r death. ector: After by the funera	atio	1 Natural 5 Pendir investi	gation	non, Day 10	11110	M		res 2□1	۷٥					
DIVISION	or Att	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 286. Plac	e of Injury - ling, etc. (S	At home, farm pecify)	n, street, factory	, office		2	28f. Location (Si City or Town		lumber or Ru	iral Route Numbe	эг,
	To the Hospital or Att within 24 hours after d To the Funerel Direct completely filled in by	Medical Co	(Check only Z Medicel	g Physician: To th	pasis of exa	y knowledge, d amination and/o	death occurred or investigation,	at the tim in my op	e, date and	d place, a	and due to the c	ause(s) ar ate and pl	id manner as ace, and due	stated. to the cause(s)	
	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifie		ner stated.		290	. License	number		2	9d. Date s	igned (Montl	n, Dey, Year)	
	- 5 + 6		Somme	1/10	ells	40		72	71	88		9/1	184		
	V		30. Name and address of person	who completed cau	se of death	(Item 23a) (Ty	/pe, Print)	1.	1	2/-		11			-65
			31. Date filed (Month, Day, Year)	16	Registrar's	Signature	(pe, Print)	rel	- 1/	16	Pl	end	alte 1	1021	222
	Sta Registr		FEB 0 5 2	100		N. A.	och								

			For State	use i			nd / De	partme	ent of		d Mental F	lygien	e 20	04	03310
-24	ka mada liki	9	Registrar  1. Decedent's Name (First, Midd	dle. Last)				CHINO		Doam	2. Date of	Reg. No Death	5.		3. Time of Death
0-	Physici	an	Wanda Ste									_	A promi	Year	210 D M
	/Medic Examir		4a. Facility Name (If not institution		treet and nun	nber)		4b. C	ity. Town.	or Location of De	Janu	0019	25 D c. County o	004	310P
	Examil	iei	Maryland	0	eral	1+0<	10:40	13	14	more			, .		
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs	. last birtho		der 1 Year	If Under 24 h	irs. 8. Date of	Birth		9. Birthpla	ace (State or Foreign
1	Director		219-88-8630	1 🗆	M 2∭ F	35	Yrs	Month 6.	hs Days	Hours M	frs. 8. Date of (Month, July	9, $19$	68	Mary	ny) Land
	p ,		Usual Residence of Decedent												
	arylar shov		10a. State 10b. Count	ry			ity, Town o Balti							10	d. Inside City Limits
	Ba-f	cto													1∑Yes 2 No
	sth with the Maryland 23s or 28s-f show ust the natified at	Dire	10e. Street and Number	11 4				10f.	Zip Code			10g. C	itizen of Wh	nat Count	ry?
	death y	Funeral Director	2527 Brookfi			dent Ever in l	16	12 Wes De		21215	(Casaity Vac as	No.	USA 14. Race		o Indian
	ter de Item	, S	11. Marital Status  1 □ Never Married 2 □ Ma		Armed For	rces?	J.S.	If Yes, s	specify Cul	oan, Mexican, Pu	(Specify Yes or erto Rican, etc.)	NO-		White, e	
336	urs aft	by F	3 Widowed 4 Divorce		If Yes, Giv Year or Da	Θ		1 🗆 Yes	s 2∭ No	Specify:			Specify:	b2	Lack
2 215-0036	within 72 hours after ene. than "natural", or Ite	ted	15. Decede	nt's Educ	ation		16a. De	ecedent's U	Isual Occu	pation		16b. h	Kind of Bus	iness/Ind	ustry
95	hin 7	pie	(Specify only high			-4or 5+)	- (G	ive kind of e. DO NO	work done T use retire	during most of ( ed)	vorking				-
22	a filed withing the state of the state of the state st	Completed	Elementary/Secondary (0-12)		College (1			sal	esper	son			var	iety	store
SE	al Hygid f other went, to	Be (	17. Father's Name (First, Middle							18. Mother's N	lame (First, Mide	tle, Maidei	n Sumame,	)	unk
\$ <u>\$</u>	should be nd Mental I marked o	2	Jesse Ster	'n											
3 E	and and is m		19a. Informant's Name/Relation								Rural Route Nur			tate, Zip (	Code)
	1 and 2 Health em 27		George Fason/	uncle	e 			and the second second		arm Road	d Baltim	ore M	1D 21	1219	
Stern Cocalimore, Marylan	ges 1 a it of Hea if item or othe		20a. Method of Disposition  1	3 □Re	emoval from S		Place of Di cemetery,	sposition (I crematory o	Name of or other pla	ice)	Date	20c. L	ocation - C	ity or Tow	vn, State
J.E	mit. Pag vartment vortant: injury c		`4 □Donation 5 🕅 Other (	Specify)	in sta	iten									
Salt	permit. Pages Department of Important: if it any injury or o		21. Signature of Euneral Survice Ronal d	S. W	ade 10	itecto	r	22. Name State	and Addr	ess of Facility	rd, 655 v	I Do	1+1	C.	
- 65	Q □ = 6 0		/ main	1/0/1	UX	MW.		Dartr	more,	1111 21	<u> </u>		TCIMO	re s	treet
			23a. Pan 1. Enter the disease shock or heart failure. Lis	or complic st only one	ations that ca e cause on ea	aused the dea ach line.	ith. Do not	enter the m	node of dy	ing, such as card	iac or respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_ a.	Pneu	mocu	Stis	SC	ouri	Mi P	reum	NIC	L		Onser and Death
	/Medical Examiner		resulting in death)		Due to (	or as a conse	quence of):		_	Λ.	(		•		
		_	Sequentially list conditions,	b.	Hegu	cred	<u>Lm</u>	mu	ne 1	)eticie	ncy =	410	trom	e	
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹	Duego (i	or as a conse	querice or):				J	r			
	ie be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c.	Due to (	or as a conse	quence of):							_	
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687	~ ~ <u>~</u>			d.											
Вох	The law requires that the death certificate be exite has been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23		come of pregn							23d. Date	of deliver	v
ă	death a atte	cia	in the past 12 months?			nth 2∏Fet ant at time of		3 ☐Ectopic 5 ☐ Other		ey .			Month		)ay Year
P.O.	at the de by the a	ıysi	9 Unknown		9□ Unkno	wn									
<u></u>	s that ned b	y P	Part II. Other significant condit	tions cont	tributing to de	ath but not re	sulting in th	e underlyin	g cause gr	ven in Part I.	23e. Di	d tobacco	use contrib	ute to the	cause of death?
r Sp.	w requires been sign should be	Completed by									1[	]Yes 2	No 3	☐ Proba	bly 4 □Unknown
ပ္ပ	awren	jet									24a. W	as an	24b. We	ere autops	sy findings available pletion of cause of
Re	The lavate has	mo									ре	topsy rformed?	dea	ath?	
ta		BeC	25. Was case referred to medic	al						26 Place of F	eath (Check onl	2 (D/No	, 1	Yes 2	:L No
<u>:</u>		To B	examiner?	-	ospital:	npatient 2	] ER/Outoa	tient 3	DOA O	hor	Home 5 □ Re		6 □Other	(Specify)	
Division of Vital Records,	g Physie ter this		27. Mannar of Death		28a. Date o	<u> </u>	28b. Tim Inju	e of	28c. Inju Wo		28d. Describ				
<u>.</u> ö	[ [ [ ]	atlo	/ 10010011(	tigation	(INOTAL)	i, Day Tour,	III	М		Yes 2 □ No					
<u>vis</u>	r Atte er de recto by th	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	d not be mined	28e. Place	of Injury - At h	nome, farm,	street, fact	tory, office			(Street ar		or Rural	Route Number,
Ö	tal or	Certification	,			9, (-,	.,,,				0.19 6.7	own, otati	*/		
	Hospital 14 hours a Funeral t		29a. Certifier 1 Certify	ing Physi	ician: To the	best of my kn	owledge, d	eath occurr	ed at the ti	me, date and pla	ice, and due to th curred at the tim	e cause(s	) and mann	ner as stat	ted.
	the special sp	Medical	one)		and mann	er stated.									
	With Voin	2	29b. Signature and title of certification of the control of the co		an	MA		2	29c. Licen:	se number		29d. Da	ite signed (	Month, D	ay, Year) I
			Ayman M	019	11/	VID			845	)		1	125	104	-
			30. Name and address of person	n who con	npleted cause	of death (Ite	1 00		A . 1	0.	1	11 -	-1		
			1-yman Mo 31. Date filed (Month, Day, Yea.	rga	1, M	egistrar's Sign	<u> </u>	aryl	and	Gene	ral	1105	Dita	) [	
	Sta Registr		rrn A	200	· Ex	Some a sign	A A	Smalle	di.						
			Pr 8. 5.2 #3 e	7 EUU"	4 Pagani	The State of	- FG	After Man . Albert Man							

		1 - For State Registrar Unpend Item	230 27 200 F	Dom ME GS	partment of Health	and Menta	n nygien	e 2001	. 000
		Registrar Oriperati Teelli     Decedent's Name (First, Middle, Las		rer ME, C	enincate or Death		Reg. No	o. C. U U 4	4 000
sicia	an	1. Decedent's Name (First, Middle, Las	st)			, Mor			
edic		ANIHON	4		I I L L IVIA			02, 200	
min	er	4a. Facility Name (If not institution, give	/		4b. City, Town, or Location	of Death	40	. County of Dea	ath
		Bon Secours Hos  5. Social Security Number 6. Secours		In yrs. last birthda	Baltimore  Ly   If Under 1 Year   If Under	24 Hrs   a Date	of Rieth	N/A	-th-1 (2)
raf tor			M 2□F	4 5 Yrs.	Months Days Hours	Min. (Mor	of Birth	9. Bil	rthplace (State or Fo.
		Usual Residence of Decedent		10		NOV,	19,11	38 171	ARYLAN
		10a. State 10b. County	1	Oc. City, Town or	Location				10d. Inside City Lie
	ctol	MARYLAND N	/A		BALTIMOR	V- Ci	TV		1/5 Yes 2 □
	Director	10e. Street and Number			10f. Zip Code		10g. Ci	tizen of What C	ountry?
		2115 W. B	ALTI MOF	RE STREE	7 21:	223		45	A.
	Funeral	11. Marital Status	12. Was Decedent Even Armed Forces?		<ol> <li>Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican</li> </ol>	gin? (Specify Yes	or No-	14. Race - Ame Black, Whi	
	by F	1 M Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 No Specify:	,	/	Specify:	
	d b		Year or Dates:					10	LACK
	Completed	15. Decedent's Ed (Specify only highest grades)		16a. Dec	cedent's Usual Occupation ve kind of work done during mosi c. DO NOT use retired)	of working	16b. K	and of Business	/Industry
	m C	Elementary/Secondary (0-12)	College (1-4or 5+)	M	F-A T	-	11.	n 1 2 11	0
	Ö	17. Father's Name (First, Middle, Last)		1-1	18 Mother	r's Name (First, A	liddle Maiden	Sumand	roulik
	o Be	CI AUTON 12	NAPI	T/11/1	10.1	1 3 14a1110 (1 1131, 11	-	Surname)	2:
	٦	19a. Informant's Name/Relationship (7	VDELL	19b Ma	iling Address (Street and Number	O /+ CE	Lumbas Cibus	Tour Class	KICKS
i.		ROSALEETILLA	IAN CMOTH	1 1 1 .	1167 0		O o	or rown, State, a	Zip Code)
	Ì	20a. Method of Disposition		20b. Place of Dis	9 4 (EDARD)  position (Name of	Date	200.16	ocation - City of	Town State
.		1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify	Removal from State	cemetery, cr	ematory or other place)	11.15	11 12	0.4	i omi, oldio
, gi		21. Signature of Funeral Service Licens		MEIRO	22. Name and Address of Facility	x -00-0	7 101	4271401	RE, MARY
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ouce		10 10 17 19 17	10 11 011	1 am	JOJEPH II.	000000	/		
an al er		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	me cause on each line.	cocaine a	inter the mode of dying, such as and alcohol intoxic		VE, 13 ory arrest,	ALTO.	Approximate Interval Between
an al er	ai Examiner	Immediate Cause (Final disease or condition	a. Narcotic,	cocaine a onsequence of):			ory arrest,	ALTO.	Approximate Interval Between
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		1	For State Registrar	State of M	aryland /	•	rtment of H			giene Reg. No. 2	004	03312
	Physicia	an	1. Decedent's Name (First, Middle, EDWIND TYUL	Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin	_	4a. Fecility Name (If not institution, s SUBORBAN HOSPITING	give street and number,			4b. City, Town, or		th	4c. Cour	nty of Death	y
	Funeral Director		5. Social Security Number 212-21-2778	.Sex 7.A	ge (In yrs. last i 22	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year) 1982	Cou	place (State or Foreign ntry) 'Yland
	ne Maryland 8e-f show	Director	Usual Residence of Decedent	ick	10c. City, To	own or Lo	ovia		т	10- 64		10d. Inside City Limits 1 ☐ Yes 2√☐ No
	ath with the 23a or 2 uzz be no	rai Dire	10e. Street and Number 3975 Rye Lane					21770		10g. Citizen d US	A	
920	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show the Medical Exactinar must be nutitled at	by Funeral	11. Marital Status  1  Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Tyes 2 1 If Yes, Give Year or Dates:	?		Vas Decedent of Hi Yes, specify Cuba □ Yes 2∑ No	spanic Origin? (: n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	В	tace - Americ Black, White, cify: whi	etc.
Maryland 21215-0036	be filed within 72 hours after death with the Marylan lat Hyglene. Id other than "natural", or litems 23a or 28e-f show event, the Medical Examination must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			(Give life. l	ent's Usual Occupa kind of work done o DO NOT use retired, mbing ass	luring most of wo	orking		Business/In	dustry
and 2	2 should be filed and Mental Hygie is marked other eumatic event, it	To Be Co	17. Father's Name (First, Middle, La Edward Tull, S	nst)	· ·			18. Mother's Na	me (First, Middle,	Maiden Sum		-
Mary	s 1 and 2 should be if Health and Mental item 27 is marked o other treumatic eve	F	19a. Informant's Name/Relationship				g Address (Street a				vn, State, Zip	Code)
Baltimore, I	permit. Peges 1 and 2 Department of Health i Important: If item 27 i any injury or other tre		Catherine Tull/ 20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	□Removal from State	20b. Place ceme	of Dispo	Rye Lane sition (Name of natory or other place		Date	20c. Locatio	n - City or To	own, State
Balt	permit. Departr Importa sny inji		21. Signatu e di Euneral Sirvice Li	Wade / Dir	ctor	St Ba	Name and Address ate Anato ltimore,	s of Facility my Boar MD 212	d 655 W.	Balti:	more S	Street
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of Vital Record		Completed							24a. Was autor perio 1 Yes		b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of 2 No
í Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Xes 2 No	Hospital: 1 Xinpat	ient 2□EF/	Outpatier	t 3 DOA Othe	)r	eath <i>(Check only o</i> Home 5 Resid		Other (Specia	fy)
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Division	To the Hospitel or Attending P within 24 hours after death.  To the Funerel Director: After t completely filled in by the funera	Certification:	3 Suicide 6 ☐ Could no determin	building,	njury - At home etc. (Specify)		eet, factory, office		City or Tox	vn, State)	liste	al Route Number,
	Ne Hospil 24 hour Ne Funera Jetely filk	edical (		Physician: To the bes xaminer: On the basis and manner s	of examination							
)	To th withir To th	Me	29b. Signature and title of certifier	and. (	OME)		29c. License 0 (5	number 236		29d. Date sig		1.7
			30. Name and address of person w	fin completed cause of	death (Item 23	a) (Type,	Print)  BRIKE, ROX	ikalub,	MO 208	52		
, ja	Sta Regist		31. Date filed (Month, Day, Year) FFB 0 5	32. Pegis	trar's Signature							

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			1- State Amend Item 11 per	Fh,G828,02/05/0	$^{4dhb}Ca$	attinent or r	Death,	Per N	2004	039	110
			Decedent's Name (First, Middle, Last)	#23a,27,20a-1	, rer T	E,6826,2	PZFT-U4eg	2. Date of Death		3. Time of D	Death
	Physicia /Medic		NATHANIE	. /		11)00	15	JAN. 16	2004	0735	$A^{M}$
.83	Examin		4a. Facility Name (If not institution, give s				r Location of Deat	Month JAN.  16, 2004  4c. County of Death  Win.  (Month, Day, Year)  (Month, Day, Year)  (Month, Day, Year)  (Month, Day, Year)  (Gould Mark  (Month, Day, Year)  (Specify: 19, 19, 19, 19, 19, 19, 19, 19, 19, 19,			
		de.	1358 NORTH CALHOU			BALTIMO				N/A	
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			Usual Residence of Decedent		/			DEPTION	747 197	FRYLAI	VD.
	nyland how	_	10a. State 10b. County	10c. Cit	y, Town or Lo	ocation		Ń		10d. Inside City	
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	death with the Maryland rms 23a or 28a-f show r rust be nutflied at	Funeral Directo	11. Marital Status	12. Was Decedent Ever in U.	5 TREET 13.	Was Decedent of H	dispanic Origin? (S	pecify Yes or No-			
က္	or Hen		1 Never Married 2 Married	Armed Forces?  1 XYes 2 ☐ No If Yes, Give				o Rican, etc.)		, etc.	
21215-0036	72 hours after natural', or Ite	d by	3 ☐ Widowed → A Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:		Specify: 31	ACK	
5	natu	Completed	15. Decedent's Educ (Specify only highest grade		(GIVE	dent's Usual Occup	during most of wo	rking 16b.	Kind of Business/li	ndustry	
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	Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, Maide	n Sumame)		
lan	Mental Mental rked tlc ev	To B	JAMES	T	HAR	RIS	DORI	2THV	W	OODS	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "natural", or Hems 23e or 28e-f show any injury or other treumatic event, the Michical Examinat must be notified at once.		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Number, City	or Town, State, Zi	p Code)	
-	and lealth m 27 har tr		DARRYL PAYTO	ON (FRIEND)	120	8 MOSH	ER ST.	BALTIME	ORE, ME	212	217
101	Pages 1 nent of H int: If Ite		20a. Method of Disposition / 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	emoval from State	emetery, cre	osition (Name of matory or other place					
Baltimore	iit. Partmer artmer prtant njury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>	ME	ETRO	Name and Address	or V: 01-	30-04 10	7LTIMOR	E, MI	),
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E	<b>美美</b>		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deatl					7210,116	Approximate Interval Between	
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Box	death certifics e attending pt d for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	I death 3	Ectopic pregnancy	1	.55		ery Day Ye	ar
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Records,	quires n sign	ed by						1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Un	iknown
000	aw requirass been si	Completed							24b. Were aut	opsy findings av	/ailable
Ä		COM						performed?	death?	2∐ No	120 01
Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?			15		th (Check only one)			
of	ding Physician: h. After this certific funeral director,	5	1X Yes 2 No	ospital: 1  Inpatient 2   28a. Date of Injury	ER/Outpatier		4 U Nursing P			y) AT SC	CENE
on	ling After fune	tlon	1 □Natural 5 □ Pending 2 □ Accident investigation	found, Day Year)	found	Worl	k? Yes 2. ZANo		ny occurred		
Division of	Attending r death. ector: After by the fune	ifica	3 ☐ Suicide 6 ♣ Could not be determined	1/16/04 28e. Place of Injury - At ho	7:05 ome, farm, str	a reet, factory, office		28f. Location (Street a	nd Number or Rur	ai Route Numbe	er,
á	s afte	Certification:	4   Homicide	Found in Res		2		1358 N. Ca Baltimore	Thoun St MD 21217	reet	
	To the Hospital or Attent within 24 hours after death To the Funaral Director:		(Check only 2 Medical Examin	ician: To the best of my kno	wledge, deat	n occurred at the tin	ne, date and place	, and due to the cause(	s) and manner as s	stated.	
×	thin 2, the I mplet	Medical	29b. Signature and title of certifier	and manner stated.		29c. License					
	To To Con	.~	7/ 0	1 1.			C.M.E			2004	
	22 6		30. Name and address of person who con	mpleted cause of cleath (Item	23a) (Tyne	Print)				77(1)	
	1 8 bg		THEVOURE Miking				Baltimon	ce, Marylan	1 21201		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	20 8					
	- TATO I I AND I d	7 1	F F F F F 7 111/L	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	44 43 000 0	7.5					

			Please 1		Denorment of Health and A		
		-	For State	State of Maryland /	Department of Health and N Certificate of Death		- / N H & H R R I h
			Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. No	3. Time of Death
т	Physicia	_	1. Decedent's Name (First, Middle, East)	1 //)-/	Som	Month Da	
,	/Medic	_	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	40	c. County of Death
	Examin	er	Arundel Medi	Cal Center	Annanals	P	Inne Alundel
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	irthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.		
1	Director		215-38-0005 10	M 2017	Yrs. Months Days Hours Mill.	8. Date of Birth (Month, Day, Yeer	06 PA
	D .		Usual Residence of Decedent	10c City To	wn or Location		10d. Inside City Limits
	aryta ehov	_	10a. State 10b. County	Q A	, i		1 ØYes 2 □ No
	Ba-f	ecto	1110	1 / JAC	10f. Zip Code	10a C	Sitizen of What Country?
	with the	ă	10e. Street and Number	21 011	0/2/5	109. 0	/ / < D
	eath Ps 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
	fter d	FE	1 Never Married 2 Married	Armed Forces? 1 □Yes 2 1 No	· m	Rican, etc.)	Black, White, etc.
200	urs a	þ	3 ⊠Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 Ø No Specify:		Specify: 13/ACK
21215-0036	72 hours after death with the Maryland naturel, or items 23s or 28s-f show lical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a	a. Decedent's Usual Occupation (Give kind of work done during most of work	16b. I	Kind of Business/Industry
2	within ene. then "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		21 - 21 5 - 1 5 - 1 5 - 1 5
	Hygier Hygier ther ti	S	17. Eather's Name (First, Middle, Last)	Cyrs .	2/1001 / eacher	e (First, Middle, Maide	Chool System
Maryland	ild be fi fental H rked of lic ever	Be	17. Partier's Ivaline (First, Middle, East)	18-00-	Alace-	07 B.	4100
Ë	hould d Men marke matic	ဥ	19a Informant's Name/Relationship (Ty)	DINEC 19	b. Mailing Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)
⊠ Z	d 2 sho th and th is m traum		Raspana Da	sis/Niece 3	427 112hrsh Alle	PALLMORE	mn 4/2/5
<u>ئ</u>	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene the firm 27 is marked other then "naturel", or items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition		of Disposition (Name of ery, crematory or other place)	Date 20c. i	Location - City or Town, State
פֿר			1 ØBurial 2 ☐ Cremation 3 ☐ R  1 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	refield Cemetery 2-7	.04 Con	steel le mo
Baltimore			21. Signature of Funeral Service License		22. Name and Address of Facility Cut	gun C Creen	e Funeral Services
ä	Depentit. Depertrimportueny injector		Naugh ( S)	100x2	8728 Liberty Rd	Pandallste	oan NO 21133
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death. Do	o not enter the mode of dying, such as cardiac		Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	cecelmon	rascular acciden	\$	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence			
- Sec	Examiner		Convention list conditions	ceepro	al hemorrhous	e-	2 weeks
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):		
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Sup to /or on a consequence	o offi		
90,	e be executed sician and burial-transit	al E	Toodking in down, and	Due to (or as a consequence	e 01).		
68760	physic the t	dica		1.			
9 ×	leath certificate attending phys I for use as the	Physician/Medic	IF FEMALE: 2	23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	th 3 ☐Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.O.	t the d by the tached	ysk	1 ☐ Yes 2 X No 9 ☐ Unknowh	9□ Unknown			
۵	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the		Part II. Other significant conditions con	ntributing to death but not resulting		23e. Did tobacco	use contribute to the cause of death?
Vital Records,	n sign	d by	type 2 Di	iabetes mel	litus	1 🗆 Yes	2 No 3 Probably 4 □Unknown
00	s been si	Completed	House ter	78000		24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Re	The law te has age 2 :	E O				autopsy performed? 1 ☐ Yes 2 💢 N	death?
ital	ysician: The is certificate his director, page	a	25. Was case referred to medical		26. Place of Dea	th (Check only one)	
>	ysici IIS Cel direc	To B	examiner? 1 Tes 2 No	Hospital: 1 X Inpatient 2 ☐ ER/C	Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specify)
n of	ding Ph h. After th funeral		27. Manner of Death 1   Matural 5 □ Pending	28a. Date of Injury 28b (Month, Day Yeer)	o. Time of 28c. Injury at Work?	28d. Describe how in	jury occurred
Division	endir eath. or: Al	Certification;	2 Accident investigation		M 1 ☐ Yes 2 ☐ No		
≅	ter de irect	ĮĮ.	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	281. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
	urs af	Ce	Would be obtained	sision. To the book of my bounded	les death and and the lines date and along	and due to the severi	(-) and
	Hosp 24 hou Fune tely fi	ica			lge, death occurred at the time, date and place and/or investigation, in my opinion, death occu		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month, Day, Year)
	F ¥ F 8		Dolonia C	Clemo	MD D48101		Jan, 29, 2004
	$\Omega$		30. Name and address of person who co	ompleted cause of death (Item 23)	a) (Type, Print)	6	10
	$\sim$		Donna Chambers	MD 2002 MC	lical Palkwan Su	Ja 350 A	nnapolis MD 21401
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	k 1.0.		
	Regist			UD COULA RESERVE	an St. Agreement		

DilliAm

		-	For State Registrar	State of Mary		•	nt of Health and <i>te of Death</i>	-	giene Reg. No.2	04	03316
			1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath Day	Year	3. Time of Death
	Physici		Plu	mmer Wiley				Januar		2004	9:35 PM
	/Medic Examin	_	4a. Facility Name (If not institution, giv	re street and number)		4b. Cit	, Town, or Location of De		77	y of Death	
			Charleston	WY			-atonsv	ille	150	Itin	10re
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In IXIM 2□F 9:	yrs. last birth	Months	er 1 Year If Under 24 H		y, Year)	9. Birthpl Count	ace (State or Foreign try)
	Director		059-03-1802	1 M 2 L F 9.	T A	rs.		vember 20	, 1912	Mass	achusetts
	pu 🖈	}	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town	or Location				10	Od. Inside City Limits
	lanyla sho	៦	Maryland Baltimo				Catonsville				1 ☐ Yes 🏋 ☐ No
	28a-1	Director	10e, Street and Number			10f. Z	ip Code		10g. Citizen of	What Coun	try?
	with responding		709 Maiden Choice	Lano			21228		United		•
	leath	era	11. Marital Status	12, Was Decedent Ever	in U.S.	13. Was Dec	edent of Hispanic Origin? ecrly Cuban, Mexican, Pu	(Specify Yes or No		ce - America	an Indian,
·0	fler of the result of the resu	Funerai	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉 No				erto Rican, etc.)		ck, White, e	
ë	hours after death with the Maryland tural', or items 23a or 28a-f show a Exartiner must be nutified at	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 No Specify:		Speci	が: Whi	te
2	in 72 hours "natural", ledical Exe	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. [	Decedent's Us	ual Occupation ork done during most of w	vorking	16b. Kind of E	Business/Ind	lustry
2		nple	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retired) al Engineer		Traffic	Enci	2002
7		ပ်		4	rie	Chanic		ann (First Mintella			.neer
<u>n</u>	0 2 0	Be	17. Father's Name (First, Middle, Last	Chester P. W	ilev			ame (First, Middle nnie Caro			
3	should be ind Mental s marked o umatic eve	은	19a, Informant's Name/Relationship			Mailing Addra	ss (Street and Number or	Dumi Pouto Numb	or City or Tour	State Zie	Corfo
	32. har		Paul Plummer	Cousin			e Acres Road				
	e c e		20a. Method of Disposition		Ob. Place of I	Disposition (N	ame of	Date	20c. Location		
5	Pages nent of int: If it iry or o		1 Burial 2 ☐ Cremation 3		cemetery Woodla	v, crematory of wn Mau:	soleum Febru	ary 2, 2	04 Wood	llawn,	Maryland
	artme artani ortani injury		*4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice	97			i				
Ba	permit. Pages 1 a Department of He Important: If item any injury or oth		I Just 2/	Cellner			and Address of Facility L Liberty Rd.,				
			23a. Party Enter the disease, or con shock, or heart failure. List only	plications that caused the	death. Do no						Approximate Interval Between
	Priysician	8 3	Immediate Cause (Final disease or condition	A11	scle	ton	ic vasci	105 5	100.00		Onset and Death
	/Medical		resulting in death)	a. Due to (or as a co			10 0000	001001	(3CM36		9-01-3
	Examiner		Sequentially list conditions	b							
	D #	iner	Sequentially list conditions, I are leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	ns uence of	n:					
	ecute and -trans	Examine	that initiated events resulting in death) Last	c. Due to (or as a co	ecoguanea a	<b>1</b> .					
60	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	E E		Due 10 (0) as a co	insequence of	.,.					
8760,	physi the b	dicai	•	d							
9 ×	eath certific attending p i for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of p	regnancy				234 D	ate of delive	N
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death	3 ☐Ectopic 5 ☐ Other (					Day Year
o.	at the de by the tached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		0 🗆 0 (					
صّ	that the the the the the the the the the th		Part II. Other significant conditions	contributing to death but no	ot resulting in	the underlying	cause given in Part I.	23e. Did 1	obacco use con	ntribute to th	e cause of death?
Vital Records,	puires 1 sign 11d be	d by						1	Yes 2□No	3 ☐ Proba	abiy 4 Dijaknown
Ö	w requir been si should I	Completed						24a. Was	an 24b.	Were autop	osy findings available
Be	The lav	щc							ormed?	prior to con death? 1 \( \text{Yes} \)	npletion of cause of
		a	25. Was case referred to medical			-	26. Place of C	1 ☐ Yes eath (Check only o		10165	20,140
	Physicien: this certific ral director,	.0	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Out	patient 3 🗆 I	OOA Other: 4 4 Norsing	Home 5 ☐ Resi	dence 6 □Ot	her (Specify	')
	g Ph er th	2	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Ti	me of jury	28c. Injury at Work?	28d. Describe	how injury occu	rred	
io	Attending I r death. ector: After by the funer	atio	1 Sending 5 Pending 2 Accident investigation		(a)	М	1 ☐ Yes 2 ☐ No				
Division	r Atte er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined			m, street, fact	ory, office	28f. Location ( City or To	Street and Num wn, State)	ber or Rura	Route Number,
ā	spital or ours afte seral Dire	Certification:									
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Medical Exa	hysician: To the best of m miner: On the basis of exa	amination and	death occurre Vor investigation	ed at the time, date and pla on, in my opinion, death of	ice, and due to the curred at the time,	cause(s) and m date and place,	nanner as sta , and due to	ated. the cause(s)
	To the Hos within 24 h To the Fun completely	Medical	one)	and manner stated			9c. License number		29d. Date signs		
	To You	-	29b. Signature and title of certifier	AAN							•
	λ		millede	a, MD		10	U7/009	3	Janua	ry 3	4,2004
	P		30. Name and address of person who	completed cause of death	1 . 4		hoice Lo	R.	12	CO 1	1 71778
	- 04	ate	31. Date filed (Month, Day, Year)	32. Registrar's	450	en	-NOICE LO	ine,100	CLIMO.	16/1.	10 21220
	Sta Regist	ate rar		EP 0 5 1004		H.	houles				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 2112 M **Physician** 2004 IAN Antonio E. Williams 31 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HEMLTHEARE ST AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1X M 2□ F 45 07/24/1958 Maryland Director 219-66-8461 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Expuritment must be confilled at once. 10a. State 10b. County 1 DXYes 2 □ No Maryland Baltimore Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 U.S.A. 508 Westgate Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housing 10 Contractor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Arthur Williams, Sr. Eliza Mae Shanks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Westgate Rd., Baltimore, Maryland 21229

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State Joyce E. Williams / Wife 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park Ceme. 02/07/2004 Baltimore, Maryland 22. Name and Address of FacilityThe Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service License 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications believe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** an 91 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig MEDICAL RESIDENT 16700 4005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 AV.e. sti-Bunney Caton 900 Emmanuel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 5 2004 Registrar

		- 1	1 - For State Registrar	State of Mary	-		t of He	alth and N	-	_	03318
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Thomas Wallace				-	and Dooth	2. Date of De Month Pepy Va	xy 02,200	3. Time of Death
7	Examin	er	4a. Fecility Name (If not institution, give Mercy Hospice  5. Social Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Sec		yrs. last birthday		Balti	ocation of Death  MOTE If Under 24 Hrs.	8. Date of Bi	' 4c. County of D	Birthplace (State or Foreign Country)
	Funeral Director			X M 2□F	66 Yrs.	Months	Days	Hours Min.	(Month, D. 05/27/		uth Carolina
	ith with the Marylan 23s or 28s-f show	ctor	10a. State 10b. County Maryland		c. City, Town or L Baltimor						10d. Inside City Limits 1    Yes 2   No
		ral Directo	10e. Street and Number 229 North Mount S			2	1217			U.S.A.	Country?
336	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Iteme eny injury or other traumatic event, the Medical Examination.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S.   13	. Was Dece If Yes, spe 1 ☐ Yes		panic Origin? (Sp , Mexican, Puerto Specify:	Rican, etc.)	Black, W	/hite, etc.
7740 215-00	ithin 72 hou ne. nen "neture Medicel E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Giv	edent's Usu re kind of wo DO NOT i	rk done du	ion iring most of wor	king	16b. Kind of Busine	
Wallace, Thomas Baltimore, Maryland 21215-0036	d be filed winter the other the	Be	8 17. Father's Name (First, Middle, Last) Eugene Wallace, S		Aut	o Mec				Automot e, Maiden Sumame)	ive
Maryl	d 2 should the and Me 17 is mark traumatic	2	19a. Informant's Name/Relationship (19a) Oralye Canty / Si	Type, Print)		-	(Street ar	nd Number or Ru	ral Route Numb	ber, City or Town, State e, Marylan	1
Jalla nore,	ages 1 an int of Heal t: If item 2 y or other		20a. Method of Disposition  1	Removal from State	20b. Place of Disp cemetery, cri	position (Na ematory or	me of other place,	)	Date	20c. Location - City Baltimore	or Town, State
Ç Baltir	permit. P Departme Importan eny injur.		21. Signature of Funeral Service Lice	''		22. Name a	nd Address	of FacilitThe	Derric	k C. Jones	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line. a	e50			such as cardiac		arrest,	Approximate Interval Between Onset and Death
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8760,	ate be executed obysician and the burial-transit	cal	resulting in death) Last	Due to (or as a co	onsequence of):						
O. Box 68	Attending Physicien: The law requires that the death certificate trade.  Geath.  Sctor. After this certificate has been signed by the attending physis  the funeral director, page 2 should be detached for use as the E	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	i⊟Ectopic p i⊟ Other (s				23d. Date of Month	delivery Day Year
rds, P.	w requires that the des been signed by the a should be detached t		Part II. Other significant conditions of	contributing to death but n	ot resulting in the	underlying	cause giver	n in Part I.			te to the cause of death?  Probably 4 Onknown
Division of Vital Records, P.O.	iician: The law re certificate has bee rector, page 2 sho	Completed							24a. Wa auto pen 1 🗆 Yes	opsy prior formed? deat	e aulopsy findings available to completion of cause of h? Yes 2 \( \sum \text{No} \)
Vita	rsician: s certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 300	Hospital: 1 ☐ Inpatient	2 ER/Outpati	ient 3 🗆 D	OA Other	26. Place of Dea	th (Check only		Specify) hospic 4
ion of	To the mospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		27. Manner of Death  1 Setatural 5 Pending 2 Accident investigatio		ear) 28b. Time Injury	of M	28c. İnjury Work 1 🗆 Y	at ? es 2 □ No	28d. Describe	how injury occurred	
Divis	To the Mospital or Attend within 2.4 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	building, etc. (	Specify)				City or To	own, State)	r Rural Route Number,
dx.	e Hosp 124 hou e Fune letely fi	Med cal		nysician: To the best of n miner: On the basis of ex and manner stated	amination and/or						
	To the within 2 To the Comple	Me	29b. Signature and title of certifier	<b>\</b>		25	C. License	number 5)		29d. Date signed (M	fonth, Day, Year)
	3		30. Name an address of pers in who	completed cause of deat	(Item 23a) T p	e, Prit)	JTU D	- Y			
	* <u>c</u> v	ate	31. Date filed (Month, Day, Year)	30 5†.   30 Registrar's	Signature	:Dal	11/91/	re //-	010	J.Cla	
	Sta Regist		FFR 0 5 200	45	K An	SALL					

		1 - For State Registrar	tate of Maryland /		rtment of I tificate of		nd Mental Hy	rgiene Reg. No. 200	+ 03319
Physici /Medio		1. Decedent's Name <i>(First, Middle, Last)</i> William John Wats	30n				2. Date of De Month	Day Year	3. Time of Death
Examin		4a. Facility Name (If not institution, give stre  Edenwald  5. Social Security Number 6. Sex		irthday)	4b. City, Town, Town of Towson			4c. County of Dea	ore
Funeral Director		217-05-3207 Usual Residence of Decedent	1 89	Yrs.	Months Days		Min. June 1		thplace (State or Foreign ountry) laryland
he Marylar 8e-f show	Director	MD Baltimore	10c. City, To		÷1				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It has the marked other than "natural", or items 23e or 28e-f show other traumatic avent, the Medical Exercites must be neitified at	Funeral	1 → ever Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1	10f. Zip Code 21 28 Vas Decedent of I Yes, specify Cub	Hispanic Origi pan, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	United Sta - 14. Race - Ame Black, Whi	ites erican Indian, le, etc.
within 72 hours ene. than "natural" ive Medical Ex	Completed by	3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade continuous processes)  Elementary/Secondary (0-12)	Year or Dates: on 16: ompleted) College (1-4or 5+)	a. Deced (Give life. L	ent's Usual Occu kind of work done OO NOT use retire	nation	of working	16b. Kind of Business	White /Industry
should be filed vind Mental Hygie I marked other t umatic avent, II	To Be Co	17. Father's Name (First, Middle, Last) Wilson Ward Watson	5+		lanager		s Name (First, Middle	<u>Banking</u> , <sub>Maiden Sumame)</sub> Eisinger	
permit. Pages 1 and 2 sho Department of Health and h Importent: If item 27 Is ma any injury or other trauma 0069.		19a. Informant's Name/Relationship (Type,  Wilson Watson/nephe  20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Rem  '4 □ Donation 5 □ Other (Specify)	20b. Place comet	20 Bi of Dispo- ery, cren iect	Lack Oak sition (Name of eatory or other pla Hill Cen	Court neteryC	Reisters Date 12/06/2004	Towson,	2113 <u>6</u> Town, State MD
permit Depart Import any in		21. Signatur vot Funayal Service Licensis  23a. Part1. Enter the disease, or complicat	One that soused the death. De	10		Road 1	owson, Mai	ryland 212	1 Home, Inc 04 Approximate
death certificate be executed  was a strength of the control of th	edical Examiner	shock, or heart failure. List only one of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence	of):	hu h	ent val	failme pailin	¢	Interval Between Onset and Death
y th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown		Ectopic pregnanc Other (specify) _	у		23d. Date of de Month	ivery Day Year
sign d be	by	Part II. Other significant conditions contrib	uting to death but not resulting	in the ur	derlying cause gr	ven in Part I.	23e. Did t	obacco use contribute to Yes 2 No 3 Pr	the cause of death?
The law ate has t page 2 s	Completed						24a. Was auto perfo 1 \( \text{Yes}	an 24b. Were at prior to death?	itopsy findings available completion of cause of
Attanding Physicien: Treath. sctor: After this certifical the funeral director, p	atlon; To Be	1 Natural 5 ☐ Pending 2 Accident investigation	1 Inpatient 2 ER/O	utpatien Time of Injury	28c. Inju Wo	ner: 4 Jurs	28d. Describe	one) dence 6 □Other (Spe how injury occurred	cify)
P dige	Certification;	4 Homicide	8e. Place of Injury - At home, f building, etc. (Specify)				City or To		
To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by	Medical	29a. Certifier (Check only 2 Medical Examiner one)  29b. Signature and title of certifier	an: To the best of my knowledge On the basis of examination a and manner stated.	ge, death nd/or inv	occurred at the ti estigation, in my o	opinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due 29d. Date signed (Mont.	to the cause(s)
10		30. Name and address of person who comp	leted cause of death (Item 23a)	(Туре, І	Priht)	129	769	2/5	12/228
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	<b>y</b>	Acousti		ing !	1700 1100	

DHMH 17 Rev 1/2001

Katson, William J

		•	For State Registrar	State of Ma	-	epartment of H De <i>rtificate of L</i>		rienta: Hygie Reg	200	4 03320
			1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Elizabeth Ce	celia Wiel:	and			2	4 04	545AM
•	Examin		4a. Facility Name (If not institution,	give street and number)			Location of Death		4c. County of Dea	
			EDENWALD			Tows			BALTIM	
	Funeral		5. Social Security Number	1□M 2NF	e (In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Bi	rthplace (State or Foreign ountry)
	Director		215-03-2362		97 '	rs.		Aug. 31,	1906 M	laryland
	and w	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mary f sho	ō	MD Baltim	nore	Tows	OD				1 ☐ Yes 2 No
	the 28a	Directo	10e. Street and Number	IOIC	1000	10f. Zip Code		109	. Citizen of What C	country?
	3a or		800 Southerly	Road Stroh	Hall	2128	б	Ur	nited Sta	ites .
	death ms 2	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba			14. Race - Am	erican Indian,
326	filed within 72 hours after death with the Maryland Hygione. Hygione instrueit, or items 23e or 28e-f show ent, the Medical Extends or resulted at	by Fur	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  ad 1 Yes 2001  If Yes, Give  Year or Dates:	No	1 □ Yes 2 💢 No	Specify:	nican, etc.)	Black, Wh	White
15-0036	72 hours "natural", dical Exp		15. Decedent	s Education	16a. [	Decedent's Usual Occup	ation	. 16	b. Kind of Busines	s/Industry
212	nin 72	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	(+)	Decedent's Usual Occupi Give kind of work done of life. DO NOT use retired	during most of work ()	ring	Departm	ent
_	be filed withital Hygiene. d other than	E O	12	Sollege (1 vers		itchboard O	perator		Store	
ᅙ	e filed al Hygi other vent, I	Be C	17. Father's Name (First, Middle, L	ast)			18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
<u>la</u>		10	John D. Schmi	dt			May T	ownsend		
Maryland 2	2 should and Men is marke raumatic		19a. Informant's Name/Relationsh	ip (Туре, Print)		Mailing Address (Street			•	
	and 2 Balth n 27 in		Charles Harris	/cousin		01 Pentland			imore, M	
ore e	iter		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from State	20b. Place of the complexity	Disposition (Name of , crematory or other place	e)	Date 20	c. Location - City o	r Town, State
Ĕ	Pages ment of ant: If it ury or o		*4 □Donation 5 □Other (Sp	ecify)	Hillton	Service C	orp. 02/0	5/2004	Towson,	Maryland
Baltimore,	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Service	1 _ (	OSTAL.	22. Name and Address		ıck Towsor 'owson, Ma		Home, Inc.
		-	23a. Pall1. Enter the disease, or a shock, or heart failure. List of							Approximate
	Physician		Immediate Cause (Final	orny one cause on each in	ie. <	Stroloe				Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a Due to (or as	a consequence of	1:24	/ ,			1 1
	Examiner				( = A = )	Winds SI	holde			240
	_	je.	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of	* /	1			1
	outed id ansit	Examiner	Cause (Disease or injury that initiated events	c.	Cina	nestive h	ent	milme		140
o,	fficate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequence of		. /	,		' /
68760	ate b hysic the bu	edlcal		d						
	:= CD cd		IF FEMALE:	20- 14						
Вох	ires that the death certif signed by the attending d be detached for use a	Physiclan/M	23b. Was decedent pregnant in the past 12 months?		2 🗌 Fetal death	3 ☐ Ectopic pregnancy			23d. Date of de Month	elivery Day Year
- 0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death	5 Other (specify)				
P.0.	hat the	F.	Part II. Other significant conditio	ns contributing to death b	ut not resulting in	the underlying cause giv	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ds,	Attending Physician: The law requires that the death cert or death.  r death.  sctor: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use.	1 by		•	•			1 ☐ Yes	2 No 3 □ F	Probably 4 Unknown
Ö	w require been si should I	Completed						24a. Was an	24h Ware s	autopsy findings available
ec Sec	e law has	ш						autopsy	prior to	completion of cause of
a	r. Th							1⊡ Yes 20	1 □ Ye	s 2□ No
Ž	certif recto	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or 1	h (Check only one)	a 500 (a	
ō	Phys this ral di	7	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie				ome 5 Residence 28d. Describe how		өсіту)
CO	ding h. After fune	io Io	1 Natural 5 ☐ Pending	(Month, Da	<i>ý Year)</i> In	jury Wor	k? Yes 2 □No			
<u>s</u>	deatl deatl ctor: y the	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of Inj	ury - At home, farr	n, street, factory, office		28f. Location (Stree	et and Number or F	Rural Route Number,
Division of Vital Records,	after Dire	Certification;	4  Homicide	building, et	c. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town, S	State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2	Medical C	(Check only 2 Medical I	g Physician: To the best examiner: On the basis o	f examination and	death occurred at the tir or investigation, in my o	ne, date and place, pinion, death occur	and due to the caus	se(s) and manner a and place, and du	as stated. se to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner sta	100.	29c. Licens	e number	29d	. Date signed (Mor	nth, Day, Year)
	F ₹ F 8			m s	Man	1 cin D	297	69	2/4	104
-	il		30. Name and address of person	who completed cause of o	leath (Item 23a) [1	Type, Print)	1 (	/		, 7/
	. (		marcolino	DA Blove			GN. Ro	16min Bo	1 Bols	4 my 2/228
	Sta	ite	31. Date filed (Month, Day, Year)	2001 32. Regist	ar's Signature	A Assales		V		
	Regist	rar	FEB	U J LUUT	CARLON OF THE	- 1		-		

Ú

FLIZABETH

		-	For Stete Regi	e strar			State o	f Mary	land .		artmen rtificate				ental Hyg	giene Reg. No.	2004		03321
	Physicia	an			(First, Middle		ルニくい	4:17							2. Date of Dea Month	Day	7004	3.	Time of Death
	/Medic Examin		MELVIN C, WEISHEIT  4a. Fecility Name (If not institution, give street and number)							4b. City, Town, or Location of Death						4c. County of Death			
	LAUIIIII	٠,	Go	ood Sa	amarita	an					1		ore C				N/A		
	Funeral Director	i		Security No		6. Sex	M 2□F	7. Age (In	yrs. last 77	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	<ol> <li>Date of Birt (Month, Day</li> <li>14</li> </ol>	v, Year)	Co	thplace ountry)	(State or Foreign
			Usuel Re	50-382 sidence of	Decedent									1 10	July 17	, 10	20   110		
	show	'n	10a. Stat		10b. County	/ h		10	ic. City, I	own or Lo			C = 4.						nside City Limits XYes 2 □ No
	the M	Director		dd. et and Num		/ A				t	3altir 101.Zip		CITY	/		10g. Citi	zen of What Co	ountry?	
	h with 23a oi af Le	ai Di		3615	Mary Av	venu	ie				21206						USA		
	ems	ner						13.	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>				
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "nature!", or items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at	by Funerai			ed 2□ Marr 4□Divorced		1 [X] Yes If Yes, Gi Year or D	ve			1□ Yes	2 <b>⊠</b> №	Specify	:			Specify: Wh	nite	
21215-0036	72 hou nature lical E	sted	^		15. Deceden	t's Educ			1	(Give	dent's Usua kind of wo	rk done d	luring mo:	st of workin	g	16b. Ki	nd of Business		
2	within ne.	Completed	Eleme	ntary/Seco	ndary (0-12)		College (			life.	oo not us Shoi	se retired	)				Shippir	nα	
0 0	filed v Hygie Sther t		17. Fathe	12 er's Name (	First, Middle,	Last)				Long	3 31101	emai		er's Name	(First, Middle,			19	
Maryland	Aental rked c	To B	Richard F. Weisheit  Richard F. Weisheit																
lar)	2 should and Mis mar				me/Relations												Town, State,		
	1 and 2 Health Sm 27 i			lotte hod of Disp	A. We	ishe	it/Da	ughte 12	20b. Plac	e of Dispo	tonewa	ne of			imore,		yland 2 cation - City or		
D D	ages of of h t: Hite for of		1 💢	Burial 2	☐Cremation 5 ☐Other (S		emoval from	State			matory`or o Of Fa			2/5/04			imore,		
Baltimore,	permit Pages I Department of H Importent: If ite any in ury or ot				neral Service		е	-	1		2. Name an		s of Facil	ity Ruc					e, Inc.
Ä	permii Depar Impor any ir		-	m	wha	L	1 Re	281			1050 '	York	Road	1 Tow	ison M	arvl	and 212	204	
			23a. Part1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death												rvai Between				
	Pnysician /Medical		disease	ite Cause ( or condition in death)		a		Or as a co										YEV	ms
	Examiner									,	UCTIL	1= 1	ial m	Dickn	y DISE	52-51	-	YU	10.5
	n =	ner	if any, le	ially list con ading to im Enter Unde	mediate rtving	<b>)</b>	Due to	(or as a co	onseque	ice of).			P.I. Land	W-W-97.16	1-21-51	, , , ,			
/	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last  Due to (or as a consequence of):																
760,	te be executed ysician and te burial-transit	cai E				<b>L</b> .		(	•	,									
89	death certificate t attending physical for use as the t															- 111			
Box	death certifica e attending ph ed for use as tl	lan/N		ALE: is decedent he past 12		2:		birth 2	Fetal de	ath 3[	□Ectopic pi					2	23d. Date of de Month	livery Day	Year
o.	0 0 2	Physician/Med	1 🗆	Yes 25 Unknown			4∐Preg 9☐Unki	nant at tim	e of deat	n 5[	Other (sp	респу)							
٠ ا	requires that the leen signed by th hould be detache	by Ph	Tall in Cities significant commodities to account the commodities of the cities of the								obacco u	acco use contribute to the cause of death?							
ords	v require been sig should b												NZ	/es 2[	□ No 3 □ Probably 4 □Unknown		4 Dunknown		
Seco	2 S	Completed													24a. Was autop		24b. Were a prior to death?	utopsy f complet	indings available tion of cause of
Vita	Thate are	e Cor	OF Mos	anno rator	rod to modica								oe Bloo	o of Dooth	1 Yes	20 No	1 Yes	3 2□	No
	Q 5	To Be		niner?	referred to medical 26. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence										ce 6 Other (Specify)				
n of	ng Ph Ifter th		Top. D. Marian Don Time 4 1000 Insurant 2004 D									8d. Describe f	Describe how injury occurred						
Division	Attending r death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be 289 Blood f Injury. At home farm street							- 33	M 1 ☐ Yes 2 ☐ No  set factory office 28f. Location /Stre					net and Number or Rural Route Number,			
Ď	el or Attend after death Director: d in by the f	Certification:	4 Homicide determined determined building, etc. (Specify)																
	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medicai C		rtifier heck only ne)	i⊠ Certifyii 2	ng Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.							s stated e to the	cause(s)					
	To the within 2 To the comple	Me	29b. Sig	nature and	title of certifie	er /	1.00	Dan	2				e number				e signed (Mon.	-	
	, v1			Im	um.	11.	11 VVV	7 400	$\nu$			115	135			1CD	rumy	1	
1	51/		560	1 Loc		VEN	BLVI	2 1	BAT	3a) (Type		D	21	239					
State Registrar		31. Date filed (Month, Day, Year)  32. Registrar's Signature  FEB 0 5 2004																	

			For State Registrar  1. Decedent's Name (First, Middle, Last)			Cer	tificate of	Death	2. Date of De	Reg. No.	2004	0 3 3 2 2			
	Physici		Milton Joseph Wis		Month 01	31	2004	7:15 PM <sup>M</sup>							
	/Medic		4e. Fecility Name (If not institution, give s				4b. City, Town, o	or Location of Death	<u> </u>	4c. County of Deeth					
	Examin	er	StellaMaris Hospice Towson Baltimore												
	Funeral Director		5. Social Security Number 213-03-5448  6. Sex 1 M 2 F 86 Yrs.  7. Age (In yrs. last birthday) Yrs.  8. Date of Birth (Month, Day, Year) 10/06/1917  9. Birthplace (State or Foreign Country) Months Days Hours 10/06/1917  Maryland												
	Dua ≱ _	-	Usual Residence of Decedent  10a, State 10b, County	10d. Inside City											
	f sho	ō	MD Baltimo	ngsvi	م ا ا			1 ☐ Yes 2√☐ No							
	permit. Pages 1 and 2 should be filed within 72 hours after death with the maryland Department of Health and Mental Hygiene. Departments if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinating the rigitive at once.	reci	10e. Street and Number		10g. Citize	en of What Cou	ntry?								
		ie D	12301 Jericho Roa	ad			2108	37	U.	U.S.A.					
		ed by Funeral Director	11. Marital Status	2. Was Decedent I	Ever in U.S	S. 13. \	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	)- 14	4. Race - Americ Black, White,				
2	or It		1 Never Married 2 Married	1 XYes 2 □ No If Yes, Give			1 ☐ Yes 2 🗓 No			Specific					
	ural,		3 XWidowed 4 □ Divorced	Year or Dates: WW II			dent's Usual Occu		White  16b. Kind of Business/Industry						
21215-0036	nation	lete	15. Decedent's Educ (Specify only highest grade	completed) (Give			kind of work done DO NOT use retire	king	(33) (4) (5)						
4	iene.	To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)  6  Lice			wyer			Lá	aw Busi	ness			
3	Hyg other		17. Father's Name (First, Middle, Last)	-				18. Mother's Nam		Maiden Sumame)					
ınıaı yıanıd	uld be Aenta rked tic ev		Adolf Wisniewski Karoline								e Tomola				
3	and h		19a. Informant's Name/Relationship (Ty)	p (Type, Print) 19b. Mailing Address (Street and Number or Rural											
	and and n 27		Kate Anne Cocore	es (daugh				rt - Perry			21128				
5	ges 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Pl	ace of Dispo emetery, crer	sition (Name of natory or other pla	ice)	Date	20c. Loc	ation - City or To	own, State			
	tment tant:		`4 ☐Donation 5 ☐Other (Specify)		Hol		and the second second second	ery   02/04				MarylaND			
baltimore,	Depar Mpor Impor Impor Impor Impor		21. Signature of Funeral Service License	90			Name and Addr					l Home, P.			
_	40280		23a. Part1. Enter the disease, or compli	nations that caused	the death			air Road -			, MD Z	1087 Approximate			
/ '00	Into taw requires that the death certaincate be executed in the has been sidned by the attending physician and sage 2 should be detached for use as the buriat-transit	ledical Certification; To Be Completed by Physician/Medical Examiner	cause. Erite. Urbertying Cause (Disease or injury) that initiated events resulting in death) Last  Due to (or as a consequence of):												
ision of Vital			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown						3d. Date of deliv Month	ery Day Year				
			Part II. Other significant conditions cor		id tobacco use contribute to the cause of death?										
	w requir been si should I									24a. Was an 24b. Were autopsy findings available					
	The lar				perfo	autopsy performed? death?  1 ☐ Yes 2 ▼ No 1 ☐ Yes 2 ☐ No									
	ang Physician: ). After this certifications of the color, it		25. Was case referred to medical				<del>-</del> ·	26. Place of Dea			1 1 1 1 1 1 1 1 1	ZLI NO			
			examiner? 1 ☐ Yes 2 🗶 No	Hospital: Other					Home 5 ☐ Residence 6 <b>X</b> Other (Specify) <b>HOSPICE</b>						
			27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work?							1001101				
	ospital or Attendi hours after death. uneral Director: A ly filled in by the fu		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i> )	ome, farm, str /)	eet, factory, office		281. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	To ti To ti Comp	ž	29b. Signature and title of cedifier  29c. License number  29d. Date signed (Mon												
)		1	/ hi	- 112			DY	3725		2	121	04			
	1/1	11	30. Name and address of person who co	empleted cause of d	leath (Item	23a) (Type,	Print)				' 7	,			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Julia 6:35 p Ε. Worthington January 2004 /Medical 4a. Fecifity Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Manor Care Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Sociel Security Number 8. Date of Birth (Month, Dey, Jan. 7, 7. Age (In vrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 ☐ M 2 🖫 F 89 271-30-1824 Columbus, Ohio Director 1915 Usuef Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important if item 27 is marked other than "neturel", or items 23e or 28e-f ehow eny injury or other traumatic event, The Muclical Exerting manal be notified at 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits ral', or items 23a or 28e-f ehov Examiner must be notified at D.C. Washington Director 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2020 F. St. NW, Apt. 511 20006 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No ff Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Š 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coffege (1-4or 5+) Registered Nurse 5+ U.S. State Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Scott LeRoy Worthington Zelda Hanby ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) May Parrott / Friend 16366 Allen Center Rd., Marysville, OH 43040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Comfort Crematory Feb. 4,2004 Alexandria, Virginia 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licenses MO1296 Hellma 5130 Wisconsin Ave., NW, Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Breast Cancer with Metastases /Medical Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. the use as IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ٥ in the past 12 months? 1 ☐ Yes 2 🖾 No Month 4☐ Pregnant at time of death Day Year 5 Other (specify) P.O. I detached 9 Unknown Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No uneral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospitaf: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 1 🗆 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation within 24 hours after death. To the Funerel Director: A 2 Accident 2 🗌 No the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) H.D D-27660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 11119 Rockville Pike, G100 , Rockville, MD Alpana Goswami M.D. 31. Date filed (Month, Day, Year) 322 Registrar's Signature State Registrar FFR 0 5 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Year

**Physician** /Medical Examiner

**Funeral** Director

the Maryland ? Is marked other than "natural", or Items 23a or 28a-1 shov traumatic event, the Medical Exam are must be notified at death 72 hours after at Hygiene. Pages 1 and 2 should be filed within permit. Pages 1 and 2 should be fill Department of Health and Mental Himportant: If Item 27 is marked ott amy injury or other traumatic even

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Baltimore, Maryland

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**Physician** /Medical Examiner

ig physician and as the burial-transit the death certificate be executed use ò ed by the a signed t of Vital Records, 2 should has page this certificate Physician: rector, After this c funeral dire or Attending death.

P.O.

3. Time of Death 1. Decedent's Name (First, Middle, Last) January 2004 Sarah Washington 1 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) Balt Baitymore >MOVE tel | Months | Days | Hours | Min. | Seb 26, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 1 ☐ M 2 💢 F 93 1910 Maryland 215-05-6779 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1X Yes 2 No Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4017 Liberty Heights Avenue 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify: black 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Armstrong Adline Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gertrude West/friend 2503 Violet Avenue #812 South Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. W 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Dir 200 Part Enter the disease, of emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 14000 Louis شين Due to for as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4□Pregnant at time of deeth 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending 2 🗆 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical Certification: To within 24 hours after death To the Funeral Director: A completely filled in by the f To the Hospital

> State Registrar

31. Date filed (Month, Day, Year)

4 - Homicide

(Check only one)

29b. Signature and title of certifier

30 Name and address of no

man 32. Registrar's Signature FEB 0 5 2004



1🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

son who completed cause of death (Item 23a) (Type, Print)

	,	For State	State	of Marylan		rtment of H		d Mental H		2004	03325
		Registrar  1. Decedent's Name (First, Middle,	Last)		001	incate or i	Jean	2. Date of	Reg. No.		3. Time of Death
Physic		James Howe		ott				Janua Janua	rv 27	2004	07:20 M
/Medi Exami		4a. Facility Name (If not institution,				4b. City, Town, or	Location of D			ounty of Death	10,120
		St. Mary's	Hospita	1		Leonar	dtown		S	t. Mar	y <b>'</b> s
Funeral Director		5. Social Security Number 237–16–7022	5. Sex 1∭ M 2□ F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of (Month, Sept	Birth $_{Day, Year)}^{Day, Year)}$	Cour	place (State or Foreign ptry) bama
p > 0		Usual Residence of Decedent  10a, State 10b, County		10c City	/. Town or Loc	cation					0d. Inside City Limits
aryla shor	7	,	ce Georg	1	Bowie						1 ☐ Yes 2 ∑ No
the N	ect	10e. Street and Number		, ,		10f. Zip Code			10g. Citize	en of What Cour	nto/?
23a or	Funeral Director	2804 Liberty					20715			USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be nutified at once.	by Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ☒ Widowed 4 ☐ Divorced	Ammed f	cedent Ever in U. Forces? 2 □ No Bive Dates: *41-7	If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2🌠 No	ispanic Origin' in, Mexican, Pi Specify:	? (Specify Yes or uerto Rican, etc.)		I. Race - Americ Black, White, Specify: white	etc.
2 hou	ted	15. Decedent's	Education		16a, Deced	ent's Usual Occup	ation		16b. Kind	d of Business/In	dustry
thin 7	Completed	(Specify only highest Elementary/Secondary (0-12) 12	College	(1-4or 5+)	life. C	kind of work done of OO NOT use retired	during most or 1)	working			
ygien ygien t, th	Con		5+		eng	ineer				drograp	hics
be fill Hall H	Be	17. Father's Name (First, Middle, L James Thomas						Name (First, Mide . Mae Hai		umame)	
hould d Mer mark matic	ို	19a. Informant's Name/Relationshi			19b Mailin	g Address (Street				Town State Zin	(Code)
od 2 s lith an 17 is i		Carole Hutchins		nter	1	Ashe Str					, 5558)
Heal Heal		20a. Method of Disposition	, , , , , , , , , , , , , , , , , , , ,	20b. P	lace of Dispos	sition (Name of place)		Date		ation - City or To	own, State
Pages nent of nt: If i		1 ☐ Burial 2 ☐ Cremation : 1 ☑ Donation 5 ☐ Other (Specific Control of Contr		n State	ametery, cren	latory or other plac	( <b>9</b> )				
permit. Departmine Imports sny inju		21. Signature of Emeral Service L RODALG S	1 1/1/2	A 23 11 (1		Name and Address ate Anat				imore S	Street
- E		23a. Part1. Enter the disease, of o	complications that	caused the death	n. Do not ente	Ltimore, or the mode of dyin	MD 21 g, such as car	diac or respirator	r arrest,		Approximate
Physician		shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on	each line.	anit	e Myo	cordi	al in	force ti	024	Interval Between Onset and Death
/Medical		resulting in death)	a. Due to	o (or as a consequ	uence of):	- Myo	Cursi	6	,		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	outcome of pregna birth 2  Fetal gnant at time of de known	ideath 3	Ectopic pregnancy Other (specify)			23	ld. Date of delive Month	ery Day Year
that if		Part II. Other significant condition	s contributing to	death but not resi	ulting in the ur	iderlying cause give	en in Part I.	23e. Di	d tobacco use	e contribute to the	he cause of death?
w requires to been signer should be	ed by							1[	□Yes 2□	No 3 ☐ Prob	ably 4 Unknown
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vitalician: certifica	Be	25. Was case referred to medical examiner?	Hospital: A			Oth		Death (Check on	ly one)		
Physic this of	2	1 Yes 2 No 27. Manner of Death		¶Inpatient 2 ☐ e of Injury	ER/Outpatien 28b. Time of	3 DOA Oth	4 🗆 1461311	ng Home 5 ☐ Re	esidence 6		y)
nding Phy th. r: After thi	tion	1 Natural 5 Pending 2 Accident investiga	(Mo	onth, Day Year)	Injury	Wor	k? Yes 2 □ No	Zod. Descrit	o now injury	occurred	
or Attendent after death Director:	fica	3 Suicide 6 Could no	ot be 28e. Pla	ce of Injury At ho	ome, farm, stre					Number or Rura	Il Route Number,
s after	Certification:	4 Homicide	bui	ding, etc. (Specify	y)			City or	Town, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (	29a. Certifier 1 Certifying (Check only one)	xaminer: On the	he best of my kno basis of examina anner stated.	wledge, death tion and/or inv	occurred at the tin restigation, in my o	ne, date and p pinion, death o	lace, and due to to occurred at the time	ne cause(s) a e, date and p	nd manner as s lace, and due to	tated. o the cause(s)
To th within To th	Me	29b. Signatura and title of certifier				29c. Licens				signed (Month,	
		DSic	rh			DA	17060	6	1 -	28.01	1
		30. Name and address of person w				Print) OICAL ART	S BLDG.	. LEONARI	TOWN,	4D.20650	)
	ate	31. Date filed (Month, Day, Year)	32	Registrar's Signa	iture						
Regis	trar	FEB 0 5 2	004	Bur B	A Ann	alle)					

DHMH 17 Rev 1/2001

JAMES HOWELL WILLETT

			1 - For State Registrar	State of M	Marylan	d / Depa		of H	ealth and Note that the second	Mental Hyg			03326
	Physici /Medio		1. Decedent's Name (First, Middle, Last Frederick E	. Zimbr						2. Date of Dea Month	Day	Year	3. Time of Death  a 105 AM
	Examir	ner	4a. Facility Name (If not institution, give	Hospita	11 Ce	nter ast birthday)	4b. City, To	SA	Location of Death	8. Date of Birth	Balt	im	Ore lace (State or Foreign
	Funeral Director			<b>X</b> M 2□F	80	Yrs.		Days	Hours Min.	Sept. 08	, <sup>Yea</sup> 1923	Wes	Virginia
~	Maryland	tor	Md. Baltimo	re	1	timore						1	0d. Inside City Limits 1 ☐ Yes 2X☐ No
じ	death with the Maryland ms 23s or 28s-f show roust be rediffed at	al Direc	10e. Street and Number 4102 Taylor Av				10f. Zip Co	1236	5		10g. Citizen of \	What Cour	utry? USA
Je r	after or ita	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give Year or Dates	;? <b>X</b> No		Was Deceder f Yes, specify	_	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White,	
215-00	thin 72 hours e. en "naturel", Medical Exa	Completed	15. Decedent's Edu (Specify only highest grad	ucation		(Give life. L		Occupat done du retired)	tion uring most of work	ing	16b. Kind of Br	usiness/Inc	dustry
And 21	I be filed wintal Hygien ed other the evant, the	Be	17. Father's Name (First, Middle, Last) Albert Zimbro	+[		Exped	iltor		18. Mother's Nam	e (First, Middle, Ward	Honey Maiden Suman		Inc.
Naryland 2121	is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than other traumatic evant, the M	To	19a. Informant's Name/Relationship (7) Mrs. Donna Bennett		er				nd Number or Rur Liven Rd.	al Route Number			
Zir	permit. Pages 1 a Department of Hec Important: If item any injury or othe		20a. Method of Disposition  1   □ Burial 2 □ Cremation 3 □ F  1 □ Donation 5 □ Other (Specify)	0	o	ace of Dispos metery, cren aney \	sition (Name natory or othe /alley	of or place, Mem	) 1. 2-7-0	Date	20c. Location -	City or To	wn, State
Ball	permil Depar Impor any in		21. Signature of Funeral Service Licens	25_	and the second	- 4	Name and A	₹8'n	Rond Fund			4	
•	Physician /Medical Examiner			ications that cause ne cause on each  a. Anoxi Due to (or as	line.						est,		Approximate Interval Between Onset and Death
1,092	nysicia ne bui	icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as Due to (or as Due to (or as	7.							1	
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al Reco	ysician: The law r is certificate has be director, page 2 sh	Completed by	Hypertensic Congestive	n Heart	Fail	ure				24a. Was a autops perform 1 Yes 2	y p ned? d	Vere autop rior to com eath?	sy findings available apletion of cause of
Division of Vital Records, P.O. Box	or Attanding Physician: The law requires that the death certifica the death. Birectoer. After this certificate has been signed by the attending pt in by the funeral director, page 2 should be detached for use as to the funeral director.	Certification; To Be	27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inj (Month, Da	ury ay Year)	R/Outpatient 28b. Time of Injury	28c.	Other: Injury a Work? 1  Ye	at as 2 No	me 5 Reside 28d. Describe ho	nce 6 ⊡0the ow injury occurre	əd	
Div	= 0 - 7	al Certii	4 Homicide determined  29a. Certifier Certifying Physical Certification	building, e	tc. (Specify)	ledge death	occurred at the	he time	date and place	28f. Location (Sti City or Town	, State)	anor as sta	tod
•	To the Hospital within 24 hours & To the Funeral I completely filled	Medical	(Check only 2 Medicel Exeminate)  29b. Signature and title of certifier  Brandes	ner: On the basis of and manner s	of examination	sident M.D.	estigation, in	my opir	nion, death occurr	ed at the time, da	ate and place, a  9d. Date signed	nd due to	the cause(s)
	Sta		30. Name and address of person who compared to the state of the state	3 9000 F	rank ran's Signatu	lin S	,	a D	rive Bo	altimor	e MI	), 2	1237
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State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2004

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Ragistrar's Signature

DHMH 17 Rev 1/2001

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**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2001 03330 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** CARNEST HIBRY /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON White Hancack, MD If Under 1 Year If Under 24 Hrs. RIOGE DAK If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Hours 15₹M 2□F 67 Yrs. March 11. 1936 Director Washington, DC 215-34-2721 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 🎇 No Director MD Washington Hancock 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 14617 White Oak Ridge 21750 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced White 'natural' Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) then Elementary/Secondary (0-12) ğ Gonstruction 10 Crain Operator 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be ith and Mental F 27 is marked of traumatic ever Pages 1 and 2 should be Margaret Federline Henry G. Bass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau 14617 White Oak Ridge Hancock MD 21750 Ruth Bass/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Nourial 2 Cremation 3 Removal from State ` 4 ☐Donation 5 ☐ Other (Specify) 01/21/04\_\_ Big Cove Tannery, PA Damascus Cemetery 21 Signature of Fundred Service License 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or occupications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 215715 Physician Stat.P Larcinama /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Dogaty Medical Evenin D0056965 MO 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTIETAN Lagristown, MD 21740 EAST 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 Goods FEB 5 Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 1 L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JAN.27,2004 WILLIAM EUGENE BOTT, SR. 1:25AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 910 BARRINGTON DRIVE WALDORF CHARLES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1<del>∏</del> M 2□ F Director 162-28-7630 68 NOV.3,1935 PA. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f ehow 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 24 E No Director MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 910 BARRINGTON DRIVE 20602 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 🍇 ☐ No Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 BANK CREDIT CLERK NAT.BANK OF WASH. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EUGENE BOTT ANNA MAE ROTHAAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOIS JEAN BOTT-SPOUSE 910 BARRINGTON DR. WALDORF, MD. 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If its any Injury or o 1 ∏ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM.GARDENS 1-31-04 WALDORF, MARYLAND 21. Signature of Fyneral Service Licenses M00479 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. LA PLATA, MARYLAND 20646 Physician MULTIPLE SCLEROSIS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examine Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours efter death.

Funerel Director: After this certificate has been signed by the attanding abusing and physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Munknown 1 Tyes 2 No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 🗆 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home Pesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After thi 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Datural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier pletely f (Check only one) To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

Registrar

State

31. Date filed (Month, Day, Year)

FEB - 5 2004

32. Registrar's Signature

		-	1 - For State Registrar	State of Maryland	-		of Health a	and Men		ene 20	04	03332
	Db		1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day `	Yeer	3. Time of Death
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F	Examin	er	4e. Facility Name (If not institution, give si	treet and number)			vn, or Location o	of Death		4c. County of		
			Union Hospital  5. Social Security Number 6. Sex	7. Age (In yrs. I	ast hirthday)	Elkt If Under 1 Y		24 Hrs. R. F	Date of Birth	Ceci		ace (State or Foreign
	Funeral Director		0.000.00	M 2⊠F 70	Yrs.		ays Hours	Min. (	Month, Day, Y	'ear)	Count	Virginia
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	with the		10e. Street and Number		-	10f. Zip Co			100			•
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ary.	should be nd Mental marked c	F	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (St	reet and Numbe				tate, Zip	Code)
	and 2 saith a n 27 is		James Ray Charles	s/Husband	P.O.	Box 26	5, Elkt	on, Ma	ryland	21922-	-0265	<b>)</b>
ore,	es 1 an of Heal fitem 2 r other	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	amount from State	emetery, cre	osition (Name of matory or other	of r place)	Date ebruar	v 1,	c. Location - C	City or To	wn, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic svent, the Medical Examiner must be notified at any injury or other traumatic svent, the Medical Examiner must be notified at ance.		21. Signature of Fineral Service Licental	1.1			ddress of Facilit OME IOR					and 21921
8760,	Physician //Medical Examiner	ical Examiner	23a. Pert1. Enter the disease, or complic shock, or neart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	CA,	NCER	OF C	INK NO	TVER	5	Approximate Interval Between Onset and Death  Z.X. MONTHS
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<u>α</u>	quires that the signed by ald be detacted	by	Part II. Other significant conditions con	itributing to death but not res	ulting in the u	inderlying caus	se given in Part I	,			bute to th	e cause of death?
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	1		UNIN HOSPITAL			CET,	ELK	TON,	MD	219	21	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB ~ 5 2004	32. Registrar's Signa	Ana	4 al 8						

ORIGINAL

			1- For State Amend Item#12	State of Marylan perFHG828 2/21/04					jiene leg. No. 2 (	004	03333
V		Щ	Decedent's Name (First, Middle, La					2. Date of Dea	th	V	3. Time of Death
	Physici /Medic		Robert Howard D	ailev				January	Day 1 4	Year 2004	6:30PM M
7	Examin		4a. Facility Name (If not institution, gir			4b. City, Town, or	Location of Dea	th	4c. County	of Death	
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	and *		Usuel Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits
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	with Ba or		844 W. Irvin Av	e.		21742	2		Usa		
	filed within 72 hours after death with the Maryland Hygiene. other than "natural; or Items 23a or 28a-f show ent, the Madical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of Hi	spanic Origin? (	Specify Yes or No-		e - America	n Indian,
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altimore,	Pages 1 nent of h int: if ite		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Special Content of the cont	Removal from State	emetery, cren	natory or other place	e)   			•	
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۵.	The law requires that the death certificate has been signed by the attending is age 2 should be detached for use as	/Ph	Part II. Other significant conditions	contributing to death but not resi	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	inbute to the	cause of death?
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<u>o</u>	ofting fun	tio	14☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work M 1□	<br Yes 2 □ No				
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	al or s afte al Dir	Certification:	4 - Holincios	building, etc. (Specify	7)			City of Your	n, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time vestigation, in my op	e, date and place pinion, death occ	e, and due to the curred at the time, d	ause(s) and ma ate and place,	anner as sta and due to	ted. the cause(s)
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			For State Registrar	Please			nd / Depa		Health and	All Copies Mental Hy		2001	. 03334
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	illed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-( ehow ant, it a Madical Examiner must be notified a	ctor	10a. State	10b. County Baltimore	е		iy, Town or Lo				<b>45</b> - 111		10d. Inside City Limits 1 ☐ Yes 2, TNo
	s 23a or 2	Funeral Director		Charles S		at Francia I	10	10f. Zip Code 21204	Historia Odaisa	Const. Van an Na	Ţ	JSA	
036	permit. Pages 1 and 2 should be lifed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Any injury or other traumatic event. It a Madical Examiner must be notified at once.  Once.	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2☐ Married 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? [X]No		was Decedent of f Yes, specify Cub 1 ☐ Yes 2 💢 No	oan, Mexican, Pue	Specify Yes or No into Rican, etc.)	)·	14. Race - Ame Black, Whi Specify: W	te, etc.
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J.	es 1 an of Heal ritem 2 rother		20a. Method of Dis			20b.	Place of Dispo	sition (Name of natory or other pla		Date		cation - City or	
Baltimore,	mit. Pag partment portant: If y injury o		° 4 □ Donation	5 ☐ Other (Specify)  Ineral Service Licens			22	. Name and Addre	ess of Facility	1.29,2004		ork, PA	17403
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II Kecords,	ate has	Completed								24a. Was autop perfo 1  Yes	osy rmed?	prior to death?	utopsy findings available completion of cause of 2 No
N 1	rnysician: In rthis certificate ral director, pag	Be	25. Was case refer examiner?	_	Hospital:			0.1	hor	eath (Check only o			
DIVISION OF VITAL	ding Pnys h. After this funeral dir	tion: To	1 ☐ Yes 2 ☑  27. Manner of Deat 1 ☑ Natural 2 ☐ Accident	.140	28a. Date of		28b. Time of Injury	28c. Inju	4 Anursing	Home 5 Resident Resid			cify)
DIVIS	I othe hospital of Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification;	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of building	Injury - At h , etc. (Speci	ome, larm, str fy)	eet, factory, office	_	281. Location (S City or Tox	Street and wn, State)	d Number or Ru	ural Route Number,
	no the Hospital within 24 hours a To the Funeral Completely filled	dical (	29a. Certifier (Check only one)	1⊠-Certifying Phy 2 ☐ Medical Exami	sician: To the be ner: On the basi and manner	s of examina	owledge, death ation and/or in	occurred at the ti restigation, in my	me, date and plac opinion, death occ	e, and due to the surred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
.39	within 2 with the Comple	Mec	29b. Signature and	title of certifier				29c. Licen:	se number		29d. Date	signed (Mont	h, Day, Year)
	. (		•	-/117-				D4	3725		1/	27/0	4
	4		30. Name and addr	ess of person who co	ompleted cause	of death (Iter	n 23a) (Type, O 1 - 10 ¶	Print) Back	Ziver N	lecte no	1 12	altim	21221
	Sta Registi		31. Date filed (Mon	th, Day, Year)	32. Reg	istrar's Sign	ature	· Ann	,	lecte no	<u> </u>		4 198

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:30PM Gordon /Medical Miriam Κ. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Hebrew Home If Under 1 Year II Under 24 Hrs. 8. Montgail Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1□M 2∏F Yrs Director 214 18 1800 Usual Residence of Decedent 2/15/1921 Maryland permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "nature". 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Tyes 2 □ No Funeral Director Maryland Silver Spring Mantgarery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 N. Leisureworld Blvd., #609 20906 $\square$ Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Completed by Specify: White 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lord & Taylor <del>Jales</del> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sol Kellert Dora Rosenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Gordon — son 999 Waterside Dr., Norfolk, VA 23510 20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Lawn Cemetery 1 / Pate / 2 0 20 4 Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/15/2004 Norfolk, VA 22. Name and Address of Facility 21. Signature of Funeral Service License H. D. Oliver Funeral Apts., 1501 Colonial Ave., Norfolk, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** THE MORS OF BOTH LYNGS /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificete Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Z No 3 Probably 4 Unknown Medicai Certification: To Be Completed by 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of death? 200110 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient Other: 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this To the Funeral Director: After this completely filled in by the funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 TYes 2 TNo investigation death. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò

Division of Vital within 24 hours e To the Funeral I

State Registrar 31. Date filed (Month, Day, Year) FEB 5 2004

29b. Signature and title of certified

29a. Certifier (Check only one)

012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

1/ Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d, Date signed (Month, Dav. Year)

				State of Ma	arylan	•			Mental Hy	giene	101	00000
			A Barrier Walter (First Mills In			Certifi	cate of L	<i>Death</i>	1	Reg. No. 🚄 💄	104	<u> </u>
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	yland now		10a. State 10b. County		10c. City	, Town or Locatio	n				1	0d. Inside City Limits
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	ath w		Rt. 4 - Box 101	River Road	d		1	9966		U.S	.A.	
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I fleat it and mented other than "natural," or items 23a or 28a-f ahow other traumatic event, the Macical Examinar must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2√ N If Yes, Give Year or Dates:			Decedent of Hi , specify Cuba 'es 2덫 No		Specify Yes or No to Rican, etc.)	- 14. Rad Bla Specif	ce - Americ ck, White, o v: Whi	etc.
Ŏ	2 ho	ted	15. Decedent's Ed	ucation		16a. Decedent's	Usual Occupa	ition	-t.:	16b. Kind of B	usiness/Inc	lustry
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ق ق	1 and 1 Health em 27 i		20a. Method of Disposition	Daugnter)	20b. Pl	ace of Disposition	(Name of		Road- M.	111SDOT( 20c. Location -		
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altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signatur of Funeral Service Licens		-		ne and Addres	-			- u= 1 1	
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	within 24 hours after To the Funeral Dir completely filled in	ledicai (	29a. Certifier (Check only one) 1 ★ Certifying Phy 2 ★ Medical Exemi	rsician: To the best of iner: On the basis of and manner stat	examinatio	rledge, death occu on and/or investig	rred at the time ation, in my opi	e, date and place inion, death occu	, and due to the o	ause(s) and ma date and place, a	nner es ste and due to	eted. the cause(s)
- 4	withii To the comp	Σ	29b. Signature and title of certifier	Lad al			29c. License			29d. Date signed		
				2000			D !	5443	2	1-3	31-0	4
	4		30. Name end address of person who co	ompleted cause of de	ath (Item :				1.9MD	213	851	
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar 5 2004	r's Signatu	ire	berte	7 -				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician Catherine Hall 12:30 PM January 2004 28, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Northampton Manor Nursing Home Frederick 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2□F 214-30-2001 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Itema 23a or 28a-f ehow digal Examiner must be notified at Yes 2 No Maryland Frederick Frederick Director 10e. Street and Number 200 East 16th Street 10g. Citizen of What Country? 10f. Zip Code 21701 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□Yes 2□XNo Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Domestic Services Domestic worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry H. Swomley Nellie May Remsberg 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathleen M. Lyons/Granddaughter 16301 Batchellors Forest Rd., Olney, MD 20832 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Its eny injury or ot once. Mt. Olivet Cemetery Feb. 2, 2004 Frederick, MD 21701 1 → Burial 2 □ Cremation 3 □ Removal from State 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Part 1. Enter the disease, or complications that closed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Approximate Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) O worney Certer, Reneaso **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Bteoporius autopsy performe 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at / Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 \ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D46075 Howeller 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary P. Howell, M.D., 65-C Thomas Johnson Drive, Frederick, Maryland 21702 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** AVERNEL CAMILLE HINDS 2004 JAN.21, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner

**Funeral** Director death with the Maryland 10a. State iral", or Items 23a or 28a-f shov Examinational be notified at Director Funeral within 72 hours after 50 Maryland 21215-0036 þ "natural" Completed the Medical 12 should be fi h and Mental F 

Physician /Medical Examiner

attending physician a for use as the burial been sign has

Physician: The law requires that the death certificate be executed this After within 24 hours a To the Funeral C

AVERICA CAMILLE

4:02P<sup>M</sup> 4c. County of Death CLINTON PRINCE GEORGE SOUTHERN MARYLAND HOSP.CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1□M 2√2F NONE 28 JAN.21,2004 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1⊈Yes 2 ☐ No MARYLAND PRINCE GEORGE SUITLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3400 CURTIS DRIVE APT . 201 20746 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📆 No Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INFANT 0 NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) AVERLON ANTHONY HINDS ALICIA CAMILLE BYAM 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVERLON A. HINDS-FATHER 3400 CURTIS DR. APT.201 SUITLAND, MD. 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ME METROPOLITAN CREMATORY 1-25-04 ALEXANDRIA, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. hore 1.RC LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that laused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VERE Due to (or as a consequence of): Sequentially list conditions, it any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a nonsequence of) Examiner Due to (or as a consequence of) Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 TNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No P 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

A and manner stated. Medical 29a. Certifier 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar Nelson Hlawode

31. Date filed (Month, Day, Year)

Washington Ral #302

ed cause of death (Item 23a) (Type, Print)

Old

Registrar's Signature

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2004

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## amend 17 per birth cert. g828 2/5/04 KB Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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		Decedent's Name (First, Middle, Last)	Cerun	cate of Death	Reg. N	02 UUL	3. Time of Death
	Physicia	P 1051/16	4			7 2004	1135 AM
	/Medica Examine	An Franklin blane /// // /		4b. City, Town, or		c. County of Death	1137
		Sinai Hospital o					
	Funeral	5. Social Security Number 6. Sex		Inder 1 Year If Under 24 Hrs hths Days, Hours Min		9. Birthpla Counti	ace (State or Foreign
	Director	Unknown Usuel Residence of Decedent	115.	54	November 1		ryland
Zapo	ě ¥	10a. Stete 10b. County	10c. City, Town or Location	1		10	d. Inside City Limits
×	d distance	ig Maryland	Baltimore				1 Yes 2 □ No
ŧ	P 22	10e. Street and Number		f. Zip Code		itizen of What Countr	у?
5-0036 72 hours after death with the Mandard	Examiner must be notified at	Maryland   10e. Street and Number   2703 Barclay Street   12. Was Darmond   12. Was Darmond   12. Was Darmond   13. Was Darmond   13. Was Darmond   14. Was Darmond   14. Was Darmond   15. Decedent's Education   (Specify only highest grede complete   15. Decedent's Education   (Specify only highest grede complete   17. Father's Name (First, Middle, Lest)   17. Father Name (First, Middle, Lest)   17. Father Name (First, Middle, Lest)   17. Father Name (First, Middle, Lest)   17. Father Name (First, Middle, Lest)   17. Father Nam		11218		SA	
ter de	finer	11. Marital Status 12. Was Do Armed 1 Never Married 2 Married 1 Yes	pecedent Ever in U,S. 13. Was I Forces? If Yes, s 2 2 100	Decedent of Hispanic Origin? (5 specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, et	
5-0036	eal, o	3 □ Widowed 4 □ Divorced Year or	Give 1 □ Y	es 2000 Specify:		Specify: 81a	ck
5-0 2 2	Scal	15. Decedent's Education (Specify only highest grade complete)	16e. Decedent's	Usual Occupation of work done during most of wa	rking 16b.	Kind of Business/Indu	istry
Z #	Pan Pan Pan Pan Pan Pan Pan Pan Pan Pan	Elementary/Secondary (0-12) College	(1-4or 5+) life. DO No	OT use retired)		ONE	
ב ב ב	Hygie Int. II	17. Father's Name (First, Middle, Lest)	2 /10	19 Mother's No.	me (First, Middle, Maide		
land d be fig		Alex Stephens			2 Jarvis		
Mary d 2 shou	umati	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	dress (Street and Number or R			Code)
_ č	alth a 27 is er tra	Sinai Hospital		BEIVEDETE			
more,	of He	20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from	20h Place of Disposition	(Name of	Data Do- I	Oh T	£ 01.1.
_	ant: I	4 Donation 5 Other (Specify)	SINA	1 1407	1-9-04	polito	ind
Balti Bemit	Departimports any inj pnce.	21. Signature of Funeral Service Licensee	22. Nam	e and Address of Facility  MALAS P  mode of lying, such as cardia.		1	2141
	. C . E . C	Handen Wim	1 1000	NA1458 2	40/W.1	et viden	S AND
	-	2. Part 1. Enter the disease, or complications that shock, or heart failure. List only on a cause or	caused the death. Do not enter the each line.	mode of bying, such as cardia	or respiratory arrest,	i i	nterval Between
	nysician Medical	Immediate Cause (Final				1	Onset and Death
	xaminer	disease or condition resulting in death) a. NE	Due to (or as a consequence	+Erocoli+	15	2	1 hours
т	<i>a</i>	EV				!	
acute	and -trens	Sequentially list conditions, if the state o	THEME PREN	of):			
, ê		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	trauterine  Due to (or as a consequence	growth i	Etarda:	tion	
ficate be	phys		Due to (or as a consequence	of):			
daath certif	nding use a	Part II. Other significant conditions contributing to					
daat	e atte	Part II. Other significant conditions contributing to	death but not resulting in the underly	ng cause given in Part I	23b. Did tobacco	use contributa to ti	ha cause of death?
r a f	by th	A Company of the Comp	,		4.0	No 3□ Proba	
as th	be d	3					
requiras t	pege 2 should				24a. Was an auto performed?	availa	autopsy findings able prior to
law a	has b				5	of de	oletion of cause ath?
2 E	r. peg				1) Yes 2	□ No 1□ Y	res 200 No
Physician: The law requires thet tha	cartifi	examiner?		Other	th (Check only one)		
2 4	er this c			28c. Injury at Work?	ome 5 Residence 28d. Describe how inju		
a fig	eth. r: Afte	1 Natural 5 Pending (Mo	nth, Dey Year) Injury M	Work? 1 ☐ Yes 2 ☐ No			
T Affe	is after deeth.  Si Director: After I  led in by the funer	3 Suicide 6 Could not be determined 28e. Place	e of Injury - At home, farm, street, fail	ctory, office	28f. Location (Street a City or Town, State	nd Number or Rural F	ło <i>ute Nu</i> m <i>ber</i> ,
المَّا و	urs af						
To the Hospital or Attending	within 24 hours after deeth.  To the Funeral Director: After this cartificate has completely filled in by the funeral director, page 2.  Madical Cartification: To De Commit	29a. Certifier Certifying Physician: To the Company one)	e best of my knowledge, death occur pasis of examination and/or investiga nner stated.	red at the time, date and place tion, in my opinion, death occu	, and due to the cause(s rred at the time, date an	) and manner as state d place, and due to th	∍d. ie cause(s)
o the	vithin o the		mer stated.	29c. License number	29d. Da	te signed (Month, Da	v, Year)
Γ.		1	•	70040362	1	-	
V	.6	30. Name en address of person who completed cau	se of deeth (Item 23e) (Type, Print)	2401 11	Belunda	TY AUX	
*	-1/	Thomas O'BriEn, M. D.	Sinai Hospin	D0040362 2401 W tal Baltin	nort, mo	2/2/	5
	State Registrar	ber der del um to della	Registrer's Signature	Rocall .			
	negistial		The Control of the	POR MANAGEMENT OF THE PARTY OF			

		1	1 = For State Registrar Amend Item//26pe:	State of Mar						giene Reg. No.	2004	03340
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Day	Year	3. Time of Death
*	Physicia		JOYCE E	LIZABETH	KIDWELL				JANUAR		2004	12:50 P <sup>M</sup>
	/Medic Examin	_	4a. Facility Name (If not institution, give si	reet and number)		4b. City	, Town, or Loc	ation of Death			unty of Death	
			MEMORIAL HOSPITA				BERLANI	Under 24 Hrs.	9. Date of Rid		LEGANY	Jana (State of Foreign
	Funeral		5. Social Security Number 6. Sex 1□	7. Age ( M 2127 F	In yrs. last birthda 79 Yrs.	Months		ours Min.	8. Date of Bird (Month, Da May 29	, 1924	Cou	place (State or Foreign htry) Virginia
	Director		Usual Residence of Decedent	A	19				ridy 227	, ± /22-T	West	· VIIgilla
	and and		10a. State 10b. County	1	0c. City, Town or	Location						0d. Inside City Limits
	Mary First	to	WV Mineral		Ft. Ash	ıby						1 ☐ Yes 2 📆 No
	r 28s	irec	10e. Street and Number			10f. Z	ip Code			10g. Citizer	of What Cou	ntry?
	th with	alD	P. O. Box 405				26719				S.A.	
	ems ems	Funeral Director	11. Wantai Status	<ol><li>Was Decedent Ev Armed Forces?</li></ol>	er in U.S.	3. Was Deci	edent of Hispa ecify Cuban, M	nic Origin? (Spe lexican, Puerto	ecify Yes or No Rican, etc.)	14.	Race - Ameri Black, White,	
9	s afte	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 XNo If Yes, Give Year or Dates:		1 🗆 Yes	2 🕅 No S	pecify:		Sp	ecity: Wh:	ite
Ş	houn tural		15. Decedent's Educ				ual Occupation			16b. Kind	of Business/Ir	dustry
Ċ	in 72	Completed	(Specify only highest grade		life	. DO NOT	use retired)	ng most of work	ing			
7 7	d with giene r tha	E	Elementary/Secondary (0-12) 8th	Conege (1-40/ 04)		Homen	naker			<u> </u>	Home	
ğ	e filed of he vent,	BeC	17. Father's Name (First, Middle, Last)				18.	. Mother's Name	_	, Maiden Su	тате)	
yland	Vents Ments urked	2	William McKener	У					Ryan			
Mar	2 sho and l		19a. Informant's Name/Relationship (Type James W. Kidwell	Husband				Number or Run			own, State, Zij 719	Code)
<u>≥</u>	and lealth m 27 her tr			Tusbarid	20b. Place of Dis			•	•		tion - City or T	own, State
Jore	ges 1 It of the it is it its or ot		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ R	emoval from State	Levels	rematory or	other place)	Jan. 2004				WV
Saitim	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show enty injury or other traumatic event, it.a Michical Examinational the notified at ange.		*4 □ Donation 5 □ Other (Specify)  21. Signature p Funeral Service License		DEVELS			f Facility Sha				
g	Departing Department of the partment	1 Sul 8ms			2:	30 East	Main S	irrer ru	шегат	WV 26	757	
			23a. Part1. Enter the disease, or comp- shock, or heart failure. List only or	tions that caused the	ne death. Do not	enter the mo	ode of dying, s	uch as cardiac	or respiratory a	rrest,		Approximate Interval Between
5	Physician		Immediate Cause (Final	0-23-33-33-33-33-33-33-33-33-33-33-33-33-	1.1	Can						Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	COUNT	_ [ ]	3				10110111113
2.8	Examiner		Socuentially list conditions	)								
-		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):							
	ecute and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a	consequence of):							
8760,	cate be executed physicien and the burial-transit			540 (0) (0)	00.100400.100 0.7.							
	physicate physicate	dical		J								
0 X	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o		- Te				23	d. Date of delin	
Вох	d for a	clai	in the past 12 months?	1 Live birth 2 4 Pregnant at ti		3 □Ectopic 5 □ Other (					Month	Day Year
o.	the by the tache	hys	9 ☐ Unknown	9□ Unknown								(
	The law requires that the de tte has been signed by the a bage 2 should be detached t	by P	Part II. Other significant conditions con	ntributing to death but	not resulting in th	e underlying	g cause given i	n Part I.				the cause of death? bably 4 DUnknown
ord	w require been signal											
ec C	e law r has be ge 2 sh	Completed	1						24a. Was		24b. Were aut prior to c death?	opsy findings available ompletion of cause of
<u> </u>		S							1 ☐ Yes	2 🗆 No	1 ☐ Yes	200 No
Vita Vita	ysician: The Is certificate hadirector, page	Be	25. Was case referred to medical examiner?	lospital:	- Canin .		Other	6. Place of Dea			70th as (Case	
ot	Phys this ral dir	. To	1 ☐ Yes 2 ☒ No  27, Manner of Death	28a. Date of Injury	28b. Tim		28c. Injury at Work?	4 Nursing H	28d. Describe			ny)
on	ding h. After fune	tlon	1. X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inju	ry M		s 2 No				
Division of Vital Records,	Attending Physician: or death. ector: After this certification. by the funeral director.	ifica	3 Suicide 6 Could not be determined	28e. Place of Injur	ry - At home, farm	, street, fact	ory, office		28f. Location	(Street and	Number or Ru	ral Route Number,
á	⊒ ji te o	Certification;	4   Homicide	building, etc.	(Specify)				O., O.	,,		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exemi	sician: To the best of	f my knowledge, dexamination and/o	eath occurr	ed at the time, on, in my opini	date and place ion, death occu	, and due to the	cause(s) a	nd manner as lace, and due	stated. to the cause(s)
	To the H within 24 To the F complete	Medical	one)	and manner stat	ed.		29c. License n				signed (Month	
1	with Con	2	29b. Signature and title of certified	TI	7	1					RY 27.	
			30. Name and address of person who	J/kc	ath (Item 22a) /Ti	De Print	D00540	704		JANUF	mr a 1	
					AL HIGHW		AVALE, N	4D 2150	)2			
	St	ate	31. Date filed (Month, Day, Year)		r's signature							
	Regist		FEB .	5 ZUU	Banes .	1	Coast )					

	c.	-	For 1 State Registrar	State of	f Mary	land		artmen rtificat				lental Hyg	giene Reg. No	2111	04	033	341
			Decedent's Name (First, Middle, Last,	)								2. Date of Dea			Vant	3. Time o	of Death
	Physicia		ETHEL KATH	RYN K	EGLEY							JANUAR	Da Y 23		Yeer 104	1:15	РМ
Н	/Medic Examin		4a. Fecility Name (If not institution, give	street and nu	mber)			4b. City,	Town, or	Location o	of Death		40	. County	of Death		
			ST. VINCENT de PA						STBUI		0.111	· · · · · · · · · · · · · · · · · · ·		ALLE			
H	Funeral		5. Social Security Number 6. Se	x ∃M 2[ <b>X</b> F	7. Age (In	yrs. lasi	t birthday) Yrs.	Months	1 Year Days	If Under:	Min.	8. Date of Birtl (Month, Day	ı, Year)		9. Birthr	olace (State	or Foreign
	Director		375 16 1710 Usuel Residence of Decedent		92		110.					SEPT 1	191	L	PEND	ISYLVA	MIA
	land ow		10a. State 10b. County		10	c. City, T	Town or Lo	cation							1	10d. Inside C	City Limits
	Man	ţō	MARYLAND ALLEGANY			FRO	STBUR	₹G								1X Yes	s 2 🗌 No
	in the	Directo	10e. Street and Number					10f. Zip	Code				10g. Ci	tizen of W	/hat Cou	ntry?	
	23a 2		100 HONEYSUCKLE	LANE					2153					.S.			
	tems rems	Funeral	11. Marital Status	12. Was Dec Armed F	orces?	r in U.S.	13.	Was Deced	dent of Hi city Cuba	spanic Orig n, Mexican	gin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)			k, White,	can Indian, etc.	
36	or l	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐ Yes If Yes, G Year or I	2∭∑No ive Dates:			1 🔲 Yes	2 <b>∑</b> No	Specify:				Specify:		WHITE	1
5-0036	be filed within 72 hours after death with the Maryland ital Hyglene. id other then "natural", or items 23a or 28e-f show event, the Medical Enablications in the rediffed at	edt	15. Decedent's Edu	cation			16a. Dece	dent's Usu	al Occupa	ation			16b. K	(ind of Bu	siness/în		
212	hin 72	Completed	(Specify only highest grad		1-4or 5+)		(Give life.	kind of wo DO NOT u	nk done d se retired	furing mosi )	t of work	ing					
2121	giene giene	E C	10				HOME	IAKER						H NWC			
nd		Be (	17. Father's Name (First, Middle, Last)									e (First, Middle,					
<u>X</u>	should be nd Mental marked o	6	JOSEPH SWART:		R				(2)			YN EMMA				- C- d-)	
Maryland	C1 G 20 20		19a. Informant's Name/Relationship (T) LYNNE SELLS	ype, Print)								al Route Numbe HINGTON				0 0000)	
	1 and Health em 27 ther t		20a. Method of Disposition		2		e of Dispo				/24/					own, State	
altimore,	permit. Pages 1 Department of H Important: If Ite eny injury or ot once.		1 Burial 2 Cremation 3 F		State					<i>e)</i> EMATO:			CUMI	BERLA	ND.	MD	
≣	permit. P Departme Importan eny injur		21. Sidnature of Funeral/Service/Licens		/					s of Facilit						STREE	T
ä	Depar Impo eny ir		>7/ arilou YY	1.50	Olver	1	SC	OWERS	FUN	ERAL	HOME	P.A.	FRO	OSTBU	JRG,	MD 21	532
760,	And the private of th	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	HZI	onsequer	nce of):	S (	Dien.	ENT	A				A	Interval Be Onset and	Death YRS
P.O. Box 68	Attending Physician: The law requires that the death certificate be executed rideath. rideath. sctor: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown		birth 2 nant at time	Fetal de	eath 3	∃Ectopic p ∃ Other (sp				-		23d. Date Mon		ery Day	Year
Records, P	uires that signed b	ρ	Part II. Other significant conditions co	entributing to	death but no	ot resulti	ng in the u	nderlying o	cause give	en in Part I			obacco /es 2		ibute to t	he cause of bably 4	death? Unknown
COL	w requir been si should	Completed						_				24a. Was		24b. V	Vere auto	opsy findings empletion of	s available
Re	The lay te has age 2	шо											rmed? 2.₩No	_ a	eath?	2 No	cause of
ta	ysician: The I is certificate ha director, page	0	25. Was case referred to medical							26. Place	of Deat	th (Check only o					
<b>&gt;</b>	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 ☐ blo	Hospital: 1	] Inpatient	2 🗆 EF	R/Outpatier	nt 3 🗆 D	Oth	97: 4 Nu	ursing Ho	ome 5 Resid	ience	6 🗍 Othe	er (Specia	fy)	
o uo	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date (Mo	of Injury nth, Day Ye		8b. Time o Injury	f i	28c. Injun Worl	/ at k? Yes 2 □	No	28d. Describe h	now inju	ry occurre	be		
Division of Vital	or Dir	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	288. Plac	e of Injury		e, farm, st	reet, factor	y, office			28f. Location (S City or Tow			er or Rur	al Route Nui	mber,
	Mospital 24 hours a Funeral 6 etely filled	edical	29a. Certifier 1 Check only one) 1 Check only 2 Medical Exam	iner: On the	ne best of m basis of exa nner stated	aminatio	edge, deat n and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s date an	and mai d place, a	nner as s ind due t	stated. o the cause	(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier					29	c. Licens	e number	·		29d. Da	ite signed		Day, Year)	
)			D 9750	Shin					1 2	690	7		TAN	CAR	7 2	3 200	4
	5		30. Name and address of person who													<del></del>	
			Harjit S. Sidhu,					lsh R	oad,	Cumb	erla	ind, MD	215	J2			
	Sta Regist		31. Date filed (Month, Day, Year)	2004 32.	Registrar's	Signatur	de l	Cont	Ters.								

		State State Registrar AMEND Item#11,12perF		artment of Health and rtificate of Death		2001.00	21. 2
		Decedent's Name (First, Middle, Last)	00/	inouto or bourn	2. Date of Dea	th 3. Time of D	Death
Physi	cian	EDDIE RAY MORRI	COM		JAN.	23,2004 12:24	
/Med Exam		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Dea		4c. County of Death	r E
Exam	iiiei	10468 SEXTANT PLACE	2	WHITE PLAINS	}	CHARLES	
Funera	1	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hr	s. 8. Date of Birth	9 Birthplace (State or	Foreign
Directo		248-11-0917 X M 20	F 46 Yrs.	Months Days Hours Mir	JULY 2	5,1957SOUTH CAR	OLIN
D >		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ncation		10d. Inside City	v I imits
anyla shov			100. Oily, Town of Ed			1 □ Yes	
the M	Director	MARYLAND CHARLES  10e. Street and Number		WHITE PLAINS  10f. Zip Code		log. Citizen of What Country?	Λ
with	흐	10468 SEXTANT PLACE	2	20695		U.S.A.	
leath ns 23	era	11 Marital Status 12. Was D	Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin?	Specify Yes or No-	14. Race - American Indian,	
ire, Maryland 21215-0036  s 1 and 2 should be filed within 72 hours atter death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or Items 23a or 28a-1 show other traumatic event, the Medical Examinat must be mutified at	Completed by Funeral	1 Never Married 2 Married 1 N Y	es 2□No	lf Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 <mark>X</mark> No <i>Specify:</i>	erto Rican, etc.)	Specify: BLACK	
21215-0036 Id within 72 hours at gione. or than "natural; or the Medical Exam.	ted	15. Decedent's Education		dent's Usual Occupation kind of work done during most of w	orkina	16b. Kind of Business/Industry	
215 Bin 7	) pie	(Specify only highest grade complet Elementary/Secondary (0-12) College	ge (1-4or 5+)	DO NOT use retired)	Urking		
d 212 filed with Hygiene. other than	S	12	SCHO				
Maryland nd 2 should be file th and Mental Hy 27 Is marked oth	Be	17. Father's Name (First, Middle, Last)	NAT.		ame (First, Middle,		
Van Men	ပ္	IVAN MORRISO			E SUE A		
Mar 12 sho h and 7 Is m traum	1	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or F			
re, M 1 and 2 Health tem 27 I		DEBRA M. PRESSLEY-SI  20a. Method of Disposition	20b. Place of Dispo	AMBERWOOD LAN esition (Name of	Date	20c. Location - City or Town, State	
ages nt of t: If it		1 Burial 2 □ Cremation 3 □ Removal fr 4 □ Donation 5 □ Other (Specify)	om State	matory`or other place)	0.04	DIMONI C O	
Baltimore, permit. Pages 1 ar Department of Healmportant: If item any injury or othe				IAPEL CEM. 11-2 2. Name and Address of Facility	0-04	DUNCAN,S.C.	
De De de de de de de de de de de de de de de		inti have 0		RAYMOND FUNERA LA PLATA, MARYL			
		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	at caused the death. Do not ent				reen
Physicia	,	Immediate Cause (Final disease or condition		O MA		Onset and D	eath
/Medica	1	resulting in death)	to (or as a consequence of):	*		*	
Examine		Sequentially list conditions, b.					
p git	iner	if any, leading to immediate cause. Enter Underlying	to (or as a consequence of):				
and 	Examin	Cause (Disease or injury that initiated events resulting in death) Last C.	e to (or as a consequence of):		_		
18760, icate be executed physician and the burial-transit			(				
	dicai	d					
certil certil nding use a	Ž		, outcome of pregnancy	-		23d. Date of delivery	
P.O. Bóx 6 that the death certiti ed by the attending detached for use as	Physician/Me	in the past 12 months?	regnant at time of death 5	Ectopic pregnancy Other (specify)		Month Day Y	ear
trithe d	hys	9 ☐ Unknown	nknown				
(A) & E 0	by P	Part II. Other significant conditions contributing	to death but not resulting in the u	inderlying cause given in Part I.		bacco use contribute to the cause of de	
cord: w require been sig					. 1∐Y	es 2 No 3 Probably 4 Du	nknown
Vital Record sicien: The law requir certificate has been si irector, page 2 should	ompieted				24a. Was a autops	sy prior to completion of ca	vailable use of
	Con				perfor 1 ☐ Yes	med? death? 2 SNo 1 ☐ Yes 2 ☐ No	
Vital F sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			eath (Check only or	ne)	
	2		1 ☐ Inpatient 2 ☐ ER/Outpatier		-	ence 6 Other (Specify) ow injury occurred	
	lo co	1.☐Natural 5 ☐ Pending	Month, Day Year) 28b. Time o	f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	200. Describe II	ow injury occurred	
Division of after death. Director: After	Certification:	2 \( \textstyle \texts	Place of Injury - At home, farm, sti		28f. Location (S	treet and Number or Rural Route Numb	)er.
Div A after Direct Dire	ertif	4 Homicide determined	ouilding, etc. (Specify)		City or Tow		
Division attention and the points after deatles Funeral Director: etely tilled in by the		29a. Certifier 1 Certifying Physician: To		h occurred at the time, date and pla			
Division  To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely tilled in by the	edical	(Check only one) 2 Medical Exeminer: On the and it	he basis of examination and/or in manner stated.	vestigation, in my opinion, death oc	curred at the time, d	ate and place, and due to the cause(s)	
To the I within 2 To the I complet	ž	29b. Signature and title of certifier	W IA	29c. License number	2	29d. Date signed (Month, Day, Year)	
•		) porest	1 all	D74 36	2	1-27-04	
		30. Name and address of person who completed	cause of death (Item 23a) (Type,	Print)	1	0646	
		13 X 9	32. Registrar's ignature	1000	, 3,	070	
	State strar	FEB = 5 20	10 Alegana	head i			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** :15AM McGee Jr. Donald Ray Jaman 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Co. Hospital
5. Social Security Number 6. Sex Hagers town
nder Year If Under
ths Days Hours Washington 8. Date of Birth (Month, Day, Year) Aug. 10, 1926 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

WV **Funeral** Months **XX**M 2□ F 77 Director 062-22-1137 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. 'Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 Ie marked other than "natural", or Itame 23a or 28a-f show any injury or other traumatic event, If a Medical Examinant must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director W Hampshire Augusta 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HC-71 Box 42C 26704 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3℃Vidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lithographer 12 Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Freda Caroline Godlove Donald Ray McGee Sr. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 6000 Nahal Dr. Frederick, Md. 21702 Michael R. McGee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1/29/04 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Winchester, Va. Omps Crematory 21. Signature of Funeral Service 22. Name and Address of Facility McKee Funeral Home Hamp. 15 E. Birch Lane Romney, amer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHENOSCIENGIS Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (c. as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy should be detached for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient P 1 ☐ Yeş 2 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After Injury atural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number at of per 30. Name and ad lete c s of death (Item 3a) (Type, Print) nous Rd Hag. Md 21742 MULL 11110 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

			. For	State of Ma					Mental Hy		gibie.	
		_	1 - State Registrar Amend Item#26p		25/04 EW C	ertificat	te of D	Death	-	Reg. No.	004	03344
ı	Physici	an	1. Decedent's Name (First, Middle, Last)	Eva	ncec	Da	Lvi	nk	2. Date of De Month	path Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or I	Location of Dea	th	4c. Co	unty of Deat	4 1000
			935 E. Old Philade				kton				Cecil	
P	Funeral Director		5. Social Security Number 6. Sec. 1	M WIVE	(In yrs. last birthda) 52 Yrs.	Months	Days	Hours Min		y, Year)	Co	hplace (State or Foreign untry) Maryland
			Usual Residence of Decedent						OCCODE	L 2/ 9	1371	
	rs after death with the Marylan I, or Items 23a or 28a-f show Cominer must be notified	ō	10a. State 10b. County		10c. City, Town or							10d. Inside City Limits 1 ☐ Yes ②XNo
	r 28a-	rect	Maryland Cecil 10e. Street and Number		North	1 East	p Code			10g. Citizen	of What Co	untry?
	ath wit	Funeral Director	2379 Theodore Road	1			21	.901		Unit	ed Sta	ites
	Items Instru	-une	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No	ver in U.S. 13	. Was Dece If Yes, spe	dent of His city Cuban	panic Origin? ( , Mexican, Pue	Specify Yes or Norto Rican, etc.)	)- 14.	Race - Amer Black, White	
900	hours after death with the Maryland tural; or Items 23a or 28a-f show al Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 🔀 No	Specify:		Spi	ecity: W	Thite
21215-0036	22 8 3	Completed	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>	(Giv	edent's Usu e kind of wo	ork done du	ion uring most of wa	orking	16b. Kind	of Business/I	industry
212	within liene.	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	) ///	Priva		rse		Me	edical	
nd	be filed tal Hygi d other event,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle			
Maryland	Men Men arke	ပို	Charles Lee Karsch		400 14-1		(2)		. Cook			
Ma	nd 2 sho lith and 27 is m r traum		19a. Informant's Name/Relationship (Ty William H. Patricl						ural Route Numb			
ore,	of Health of Health filem 27 rother tr		20a. Method of Disposition  1XX Surial 2 Degenation 3 R	•	20b. Place of Disc	position (Na.	me of		North Es	20c. Locati	ion - City or 1	Town, State
Baltimore,	Pag nent ant: I ury o		'4 □ Donation 5 □ Other (Specify)	emoval from State	North Ea Cemetery			200		North		, Maryland
Bal	permit. Pag Department Important: sny injury c		21. Signature of Fuse at Service Li	<b>S</b>					rouch Fu			ry1and 21901
			23a Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	ne death. Do not e						st, Ma	Approximate
	Physician		Immediate Cause (Final disease or condition	Premi	aru f	en	bor	real	car	101	1	Onset and Death
₩.	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					,,,,		, 90
	.ef	Jer.	if any, leading to immediate	Due to (or as a	consequence of):							
¥.	ocuted and transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	»								
760,	be executed sician and burial-transit	cal Ex	resulting in death) Last	Due to (or as a	consequence of):							
7	# × 8			i								
Вох	death certificat e attending phy d for use as th	an/M	23b. Was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth 2		□Ectopic p	regnancy			23d.	Date of deliv	,
В	0 0 0	Physician/Med	in the past 12 months? 1  Yes 2  140 9  Unknown	4□Pregnant at tir 9□ Unknown		Other (s					Month	Day Year
<b>₽</b>	5 20	by Ph	Part II. Other significant conditions cor	ntributing to death but	not resulting in the	underlying o	ause given	in Part I.	23e. Did t	obacco use o	contribute to	the cause of death?
Vital Records,	w requires been sign should be								1 🗆	Yes 2 DrN	o 3□Pro	bably 4 Unknown
ecc	e law re has be re 2 sho	ompieted							24a. Was	osy	prior to co	opsy findings available ompletion of cause of
		O	OS Was seen intermed to make itself						1 ☐ Yes	500	death?	2□ No
Z X	Physician: this certifica ral director, p	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	2 ER/Outpatie	ent 3 DC	Other		ath Check only Iome 5 Tosi		Other (Speci	in mtherizon
	ding Ph h. After th funeral	on: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	(eer) 28b. Time Injury	of 2	28c. Injury a Work?	at	28d. Describe		<del></del>	W. T. Co. T. Co. I.
Division	Attending r death. sctor: After by the fune	icati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home farm o	M troot factor		es 2□No	296 Logstion /	Ctroot and Mi	m bos os Ch	To the Marshau
=	2 # 5 E	Certification;	4 ☐ Homicide determined	building, etc.	(Specify)	rieer, lactor	у, опісе		City or To		mider or Hur	ral Route Number,
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	edical (	29a. Certifier  (Check only 2 Medical Exemin	sician: To the best of e	my knowledge, dea	th occurred	at the time	, date and place	e, and due to the	cause(s) and	manner as	stated.
	thin 2, or the P	Med	29b. Signature and title of certifier	and manner state	d.		c. License			29d. Date sig		
)	To To		Mechil	land	COS N	D	DA	-14-C	6	Jan	1.4	2004
	10	n	so pame and address of person who co	mpleted cause of dea	th (Item 23a) (Type	Print) 12	- 11				100	
	Sta	10	31. Date filed (Month, Day, Year)	OVUS 32. Registrar's	STYPECT S Signature	t C	xut	IMOY	e, m	Dá	120	7
	Registr			004	the still got	4064	and a second					

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	•	Reg. No. 2	04 03345
	Discontact		Decedent's Name (First, Middle, Lest)	2. Date of De Month	path Day	3. Time of Death
0	Physici /Medic		Helen <sub>e</sub> Mae Poland		8,2004	11:10pm
)	Examir		4a Facility Name (If not institution, give street and number) 4b. City, Town, or			of Death
			St. Vincent de Paul Nursing Center   Frostb	_	Alle	
	Funeral Director		214-12-3128 1 M 2 XF 92 Yrs. Months Days Hours Min.	Feb. 1	th ly, Year) 3,1911	9. Birthplace (State or Foreign Country) W.Va.
	end *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Many f sh	ō	MD Allegany Westernport			1x⊡xYes 2 □ No
	r 28a	9	10e. Street and Number 10f. Zip Code		10g. Citizen of W	That Country?
	ath witi	raiD	204 Kelley Avenue 21562		U.S.	Α.
20	s 1 end 2 should be filed within 72 hours after death with the Marylend f Health end Mental Hygiene. It was 23e or 28e-f show tem 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1  Never Married 2 Married  1 Yes, Size  1 Vidowed 4 Divorced  12. Was Decedent of Hispanic Origin? (S	Specify Yes or No to Rican, etc.)	14. Race Black Specify:	- American Indian, k, White, etc. White
21215-0020	2 hou	8			16b. Kind of Bu	
215	hin 7.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  El a man has been	rking		
7	giene giene	S	4+ School Principal		Educat	
nd	tal Hy	Be	17. Father's Name (First, Middle, Last)  18. Mother's Nar		Maiden Sumame	9)
₹	should be and Mental marked of	၉		ian Bai		
Maryland	and 2 should be filed withir alth end Mental Hygiene. 27 la marked other than er traumatic event, the M	JS	19a. Informant's Name/Relationship (Type, Print)  Marshall E. Wilson, Jr./nephew 509 1/2 F Stree		-	
	1 end Health em 27 lother tr		- 40	Date		Dity or Town, Stat 21550
Baltimore,	permit. Pegas 1 e Depertment of Hea <b>mportant: If Item</b> Iny Injury or othe		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)			= ==7=341 -0
표	it. Per		4 □ Donation 5 □ Other (Specify) Potomac Memorial  21. Signature of Funeral Service Licensee 22. Name and Address of Facility	1/31/0	4 кеу	ser, WV
Ba	permit. Pegas 1 Depertment of H Important: If ite any Injury or ott		Harold Dean Rofsinger P.O. Box 912, K	eyser,	WV 267	'26
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final			Onset and Death
	Examiner		disease or condition resulting in death)			3 mouthy
		ē	Due to (or as a consequence of):			
	uted d ansit	Examiner	Smulantially list conditions b. Due to for as a consequence of).			j
9	icate be executed physician end s the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.			
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Вох	eath ce attandii I for use	Physician/		12 1 - 1 -		
P.O.	at the de by the a	ysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		4.4	tribute to the cause of death?
	ras thet tigned by be deta	=	Dementie	10	Yes 2 No	3 Probably 4 Unknown
of Vital Records,	The law requires thet the death certificate be executed at has bean signed by the attanding physician end paga 2 should be detached for use as the burial-transit	Completed by	Dementier Poor oral intake	24a. Was perfo	an autopsy med?	24b. Were autopsy findings available prior to completion of cause
Rec	The law ate has paga 2:	립				of death?
<u>a</u>	ician: Th cartificate ractor, pa		25. Was case referred to medical 26. Place of Dea	101		1 ☐ Yes 2 ☐ No
⋚	99	o Be	examiner?	ath (Check only o	<i>ne)</i> dence 6 □Othe	- (C*-)
	a Phys erel d	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		now injury occurre	
<u>o</u>	Attending in death.  Sctor: After by the fune	atio	1 Natural 5 □ Pending (Month, Dey Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
Division	er de by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox		r or Rural Route Number,
ō	rs effe	Ç	Summing, O.S. (Openity)		in, oldio,	
	To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completaly filled in by the funer	edicai	29a. Certifier  (Check only one)  1 Certifying Phyalclen: To the best of my knowledge, death occurred at the time, date and place, consider the time of the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the or rred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	Vithin Fo the	¥ e			29d. Date signed	(Month, Day, Year)
			296. Signature and title of certifier  H. Chrotani.  29c. License number  D 5 8853		1/20	1/4
	b		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Habib Chotani, MD - 130 Penn Ave, Cumber1	and, M	D 21502	
	Star Registra	_	31. Date filed (Month, Day, Yeer) FEB 0 5 2004	,		

DHMH 16 Rev 6/95

		ı	1 - For State Registrar	State of Ma		partment of	Health and	Mental Hy	giene Reg. No. 20 (	14 03346
			Decedent's Name (First, Middle, La	st)				2. Date of De	ath	3. Time of Death
	Physici /Medio		Delphy N	/lae	Peer			Month	a7° c	19 22:20M
	Examin		4a. Facility Name (If not institution, giv	street and number)	1, 1	4b. City, Town	, or Location of Dea	th	4c. County o	
			Sacred Ha	art Hos	sprtal	100	mber 10	JG.		gany
н	Funeral Director		5. Social Security Number 6. S 218-16-2722	ex □ M 21XF 7. Age	(In yrs. last birthda Yrs.	Months Day			3, 1922	9. Sinthplece (State or Foreign
			Usual Residence of Decedent						,	
	nylan how		10a. State 10b. County Minera	1	10c. City, Town or Wile	v Ford				10d. Inside City Limits
	Ba-f	cto				,				1 Tes X No
	within 72 hours after death with the Maryland ane. than 'naturel', or Items 23a or 28a-f ehow in Medical Ezainirer mult be indiffed al	Funeral Director	P. O. Box 189			10f. Zip Code	26767		10g. Citizen of Wh	
	ems Serin	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	. Was Decedent of	of Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No	14. Race	- American Indian, White, etc.
36	or It	by Fu	1 Never Married 2 Married	1 □ Yes 2 📉 N If Yes, Give	0	1□ Yes 2□ N		,		white
21215-0036	hours ture!	q pe	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Education	Year or Dates:	16a. Dec	edent's Usual Occ	cupation		16b. Kind of Bus	
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ם	ould be filed Mental Hygid arked other atic event, I	Be	17. Father's Name (First, Middle, Last, Harvey D. Sach					me (First, Middle Clites Sa	, Maiden Sumame,	
yla	should Ind Meni	၉					1			
Maryland	1 and 2 sho Health and I Iom 27 is ma		19 Informant's Name/Relationship ( George Peer	<sup>Type, Print)</sup> husba	ind P.C	Box 18	et and Number or R	Wiley	Ford	WV 26767
Baltimore,	t if		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dis Fort Ashby	cosition (Name of ematory or other c Cemetery	place)	Dete 1/31/2004		ity or Town, Stete
altin	permit. Pag Department Important: I eny injury o		*4 □Donation 5 □ Other (Specification of Funeral Service Licer			22. Nan <b>Sezirb</b> e	±#isFtineral H	lome, PA		
Ö	Depa impo eny is		L-James 1	Devel	u	•	rginia Avenu		rland, MD 2	1502
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death. Do not e	nter the mode of d	tying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CERE	BROVAS	CULAR	Accid	ENT		Onset and Death
	/Medical Examiner		resulting in death)		consequence of):					
10		_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to /or as a	consequence of):					
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1-	execunate and and and and and and and and and and	Exar	that initiated events resulting in death) Last	C Due to (or as a	consequence of):					
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98	ntificating phy as th		(EFFINALE							
Вох	eath certific attending p	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		□Ectopic pregnar	ncy		23d. Date	
E	e dea the at hed fc	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at t	ime of death 5	Other (specify)			Monti	n Day Year
P.0	The law requires that the de ste has been signed by the a bage 2 should be detached f	P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying cause	given in Part I.	23a. Did t	obacco use contrib	ute to the cause of death?
Records,	uires tha signed Id be de	d by	CONGESTIV		_	AILUR	•	10	***	☐ Probably 4 ☐Unknown
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		0	25. Was case referred to medical		· · ·		26. Place of De	1 ☐ Yes eath (Check only o		Yes 2 No
of V	78 d ls	To B	examiner? 1 🗆 Yes 💈 No	Hospital: Inpatier	t 2 ER/Outpati	ent 3 DOA	Other: 4 Nursing	Home 5 Resi	dence 6 Other	(Specify)
			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	of 28c. In	york?	28d. Describe	how injury occurred	
sio	or Attending ifter death. Director: Aftei in by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b				☐ Yes 2 ☐ No			
Division	or Attendater death Director: In by the	Certification:	4 Homicide determined	28e. Place of Injui building, etc.	ry - At home, farm, s (Specify)	street, factory, offic	œ ·	28f. Location (. City or To		or Rural Route Number,
_	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by		29a. Certifier 1 Certifying Ph	ysician: To the best of	f my knowledge, de	ath occurred at the	time, date and place	e, and due to the	cause(s) and manr	ner as stated.
	n 24 } n 24 } he Fu	Medical	(Check only 2 Medical Exar	niner: On the basis of and manner stat	examination and/or	investigation, in m	y opinion, death occ	urred at the time,	date and place, an	d due to the cause(s)
	To the traction of the tractin of the traction of the traction of the traction of the traction	Σ	29b. Signature and title of certifier	$\mathcal{O}$	0	29c. Lice	ense number		29d. Date signed (	
			raul J. In	vergoos	KMO	,	3774		JANUARY	22 2004
	2	1	30. Name and address of person who	M.	ath (Item 23a) (Type	e, Print)	0 0	0		21502
	_		PAUL T. LIVE!  31. Date filed (Month, Day, Year)	V GOOD MD		ETON D	RIVE CU.	MBEELL	and mo	21502
	Sta Registr	130	FEB = 5 (	.004 Jan.		hode o				

		For State Registrar	State of Maryla		artment rtificate			Mental Hy	giene Reg. No. 20	nu n	331
Physiciar /Medica		1. Decedent's Name (First, Middle, Last Naomi F	•	Rice				2. Date of De Month Jan 29	nath Dav	Year	ne of Death
Examine	r	4a. Facility Name (If not institution, give Millennium Health	Center		Anna	apol				Arundel	
Funeral Director		5. Social Security Number 6. Se 214-05-7783	x 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Months (	Days	If Under 24 Hr Hours Mir	8. Date of Bir Month, Da Aug 2	7, 1917	9. Birthplace (Si	tate or Fore
Maryland 1-1 show iffed at	tor	MD 10b. County Anne A		City, Town or Lo Edge	ewater						de City Lim
3a or 28a		10e. Street and Number 144 Washington S	treet		10f. Zip C		21037		10g. Citizen of W	hat Country?	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at To Bo Completed Hy European Discovery.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Was Deceder If Yes, specify	~	panic Origin? ( , Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Race Black Specify	e - American India k, White, etc. white	in,
giene. sr than "natur. Ine Medical.	ошріете	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	(cation le <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual ( kind of work DO NOT use re Rep	done du retired)	uring most of we	orking	16b. Kind of Bu		
should be filed within and Mental Hygiene.  s marked other than " umatic event, the Mac	e n	17. Father's Name (First, Middle, Last) <b>Unknown</b>					18. Mother's Na UNKNO		Maiden Sumam	9)	
Health and I Healt		19a. Informant's Name/Relationship (7) Randy Rice	rpe, Print) SON	19b. Mailir 103	ng Address (S 6 Suga	Street ar	nd Number or F aple Dri	ve David	er, City or Town, S dsonville	State, Zip Code) MD	2103
r in in in		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State Hi	Place of Dispo cemetery, crei IICrest Me	sition (Name matory or othe emorial F	of er place Park	)	Date 2/3/2004	20c. Location - Cumbe	City or Town, Sta erland	te M[
Departmen Important any injury once.		21. Signature of Funeral Service Licens	Derple	22				Home, P.A ue; Cumbe	rland, MD	21502	
Wedical changing the purial-transit the burial-transit  the burial-transits the burial-transit	Z Z	shock, dy heart failure. List only of the control o	a. Due to (or as a conse	quence of):	Loryte	Nu	,α				l Between and Death
ate has been signed by the attending physicial page 2 should be detached for use as the burnhoted hy Dhysicial Medical	ysiciarymedica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d.  23c. If yes, outcome of pregri 1 Live birth 2 Fer 4 Pregnant at time of 9 Unknown	aldeath 3□	Ectopic preg				23d. Date Mon	e of delivery th Day	Year
signed b		Part II. Other significant consitions co	ntributing to death but not re	sulting in the u	nderlying cau	se giver	n in Part I.		obacco use contri res 2 \( \square\$ No		of death?
is certificate has been signe director, page 2 should be con Re Completed by	naidinos	Ger	real De	lsly				24a. Was autor perfo 1 🗆 Yes	rmed) de	/ere autopsy findi rior to completion eath? □ Yes 2□ No	ngs availa of cause
this certificate	0	25. Was case referred to medical examiner?	Hospital:	TER/Outrotion		Other		ath (Check only o			
Attending Frigs of death. ector: After this of by the funeral dire		27. Manner of Dea h  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury		. Injury a Work? 1 🗆 Ye			dence 6 Othe		
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Madical Certification:	Ser mice	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	eet, factory, o	office		28f. Location (S City or Tox	Street and Numbe vn, State)	r or Rural Route	Number,
within 24 hours after to the Funeral Directory (completely filled in by Medical Certil		29a. Certifier (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at vestigation, in	the time	e, date and plac nion, death occ	e, and due to the urred at the time,	cause(s) and man date and place, a	ner as stated. nd due to the cau	se(s)
within To th comp	Ē	29b. Signature and title of certifier			29c. L	icense	number 628		29d. Date signed	(Month, Day, Yea O4	ar)
4		30. Name and address of person who collising Chopra 31. Date filed (Month, Day, Year)	ompleted cause of death (Ite			) Ric	dgely Av	enue An	napolis M	1D 21401	

		2	1 - For State Registrar	State of Mary	land / Dep	artmer	nt of H	lealth ar Death	nd Ment	al Hygi	ene g. No.	200	4 03	341
	Physic	ian	Decedent's Name (First, Middle, La     PEARL SOPHIA						N	ate of Death Ionth	Day	Year	3. Time of	
Yes	/Medi		4a. Facility Name (If not institution, gire			4b Ciby	Town	Location of 0	01		22	04 unty of Deat	2330	М
	Exami	ner			IICE	4D. City		VILLE	Dealli			MONTG		
	Funeral		MONTGOMERY HOSPIC  5. Social Security Number 6.5		yrs. last birthday)		er 1 Year	If Under 24	Hrs. 8. D	ate of Birth Month, Day,				Foreign
	Director		Usual Residence of Decedent	1□M 2\F 89	Yrs.	Months	Days	Hours	Min. DE	Month, Day, C 4 19	14 14	MA	hplace (State of nuntry) RYLAND	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show important; If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, I'm Marical Exemites I mail be notified at ance.	<u>_</u>	10a. State 10b. County		c. City, Town or Lo								10d. Inside Cit	,
	28a-f	Director	MARYLAND MONTGON  10e. Street and Number	IERY	SILVER						- 0.11		1 Tes	2 110
	with s or	ä	15311 BEAVER BRO	OOK COURT		107. 21	p Code 2085	:3		10		of What Co	untry?	
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Dece			n? (Specify Y	es or No-			ncan Indian,	
9	or iter	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 No				spanic Origin n, Mexican, P	Puèrto Rican	, etc.)	1	Black, White		
93	ours,	d by	3 🌠 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	201 No	Specity:			Spe	ecity: W	HITE	
5-0	72 h	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	kind of wo	ork done d	furing most of	f working	16	6b. Kind a	of Business/	Industry	
21215-0036	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT L EACHE		)		į	SCH	OOL		
	Hygin Hygin Sther ent, I		17. Father's Name (First, Middle, Last	)		710111		18. Mother's	Name (Firs.	t, Middle, Ma				
Maryland	Mental Parked of	To Be	JOHN WILLIAM HE	ENDLEY						METZNE		,		
ary	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Addres	s (Street a	and Number o	or Rural Rou	te Number, (	City or To	wn, State, Z	(ip Code)	
	1 and 2 Health a em 27 is ther tra		ANNA CROWE / NIEC	CE	31 8	. Cr	anber	rv Swa	amp Dr	ive, I	rost	burg.	MD 2153	2
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	I .	Ob. Place of Dispo	sition (Na	me of		Date			on - City or		
Ē	Pages ment of I ant: If Its ury or o		`4 □Donation 5 □Other (Speci	(y)	IETROPOL1	TAN	CREMA	TORY 1	1/23/0	4 R	OCKV1	[LLE,	MD	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature on Funeral Service Lice	Da land	22	2. Name a	nd Addres	s of Facility		60	) W.	MAIN	STREET	
	005 e a		Krulou 1	11 Source	SC	WERS	FUNE	ERAL HO	OME, P	.A. FF	ROSTB	URG,	MD 2153	
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	static Me			g, such as car		ratory arres	τ,		Approximate Interval Betw Onset and D Years	een
		cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Indertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or se a con										
P.O. Box 687	death certifica e attending ph d for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖾 No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic p Other (sp						Date of delin	,	ar .
rds, I	w requires tha been signed should be de	by	Part II. Other significant conditions of	contributing to death but no	t resulting in the u	nderlying o	cause give	n in Part I.	2:	3e. Did tobae 1 ☐ Yes			the cause of de	
	The lar ate has page 2	Completed								4a. Was an autopsy performe	-	b. Were aut prior to c death? 1 \(\sum \) Yes	opsy findings a ompletion of ca	vailable use of
Vital	ician certifii rector	Be	25. Was case referred to medical examiner?	Li annitati			1	26. Place of	Death (Che					
of	Phys this al dii	P.	1 ☐ Yes 2 💢 No 27. Manner of Death		2 ER/Outpatien			4 🗀 IAGISII		Residence			iy) Hospi	ce
	fune	io	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	м 2	28c. Injury Work	?	28d. D	escribe how	injury occ	curred	- 3300000000000000000000000000000000000	
Ä	or Atten tter deat irector: n by the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined		At home, farm, str pecify)			es 2 No	28f. Lo	cation (Streety or Town, S	et and Nu State)	mber or Rui	ral Route Numb	9 <i>r</i> ,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exar	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, death mination and/or in	occurred vestigation	at the time i, in my op	e, date and pi inion, death o	lace, and du occurred at th	e to the caus ne time, date	se(s) and and plac	manner as	stated. to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier			290	c. License	number		29d	. Date sig	ned (Month,	Day, Year)	
•			I Chilie by	age		I	04245	2		Ja	nuar	y 27,	2004	
	10		30. Name and address of person who CHITRA RAJAKOPAL				ILL R	OAD, R	OCKVII					
	Sta Registr		31. Date filed (Month, Day, Year)  FFB - 5	32. Registrar's S		Mars	M. P.	7						

			1 - For State Registrar Amend Item			epartment of F		Mental Hyg	iene	
			Registrar Pitel G I Lettin     Decedent's Name (First, Middle)		20 2/21/04	wertinicate or i	Deam	2. Date of Deat	eg. No. 200	3. Time of Death
	Physic /Medi		ROBERT FRANC	CIS SWEITZEI	R, SR.			JANUARY	Day Year 28 2004	7:05 A M
	Examir		4a. Fecility Name (If not institution			4b. City, Town, or		th	4c. County of Deat	
			FROSTBURG VI			FROST	BURG If Under 24 Hrs	2 0 0 1 1 2 0 1	ALLEGANY	
	Funeral Director		5. Social Security Number 219 03 8224	1 X M 2 T E	ge (In yrs. last birti	hday) If Under 1 Year Months Days	Hours Min		Year) Co	hplace (State or Foreign ountry) LAND
	laryland show		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mary 9-1 sh	tor	MARYLAND ALLEGA	ANY	FROST	BURG				1 X Yes 2 □ No
	ith the M or 28e-1	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	untry?
	s 23s	ral	103 FIRST STE		•	215			U.S.	
36	be filed within 72 hours after death with the Maryland hat Hygiene. ad other than "natural", or items 23s or 28e-f show event, the Medical Exartirat must be rectified at	by Funeral	11. Marital Status 1 □ Never Mamed 2 □ Marn 3 □ Widowed 4 ☑ Divorced	ied 12. Was Deceden Armed Forces 1 ☐ Yes 2 K If Yes, Give Year or Dates:	? ] No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (§ .n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	e, etc.
9-0	72 hours natural', licel Exp	ted	15. Decedent	's Education		Decedent's Usual Occupa	ation		16b. Kind of Business/	WHITE
21215-0036	within 7 jiene. r than "n	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of work done of life. DO NOT use retired BARTENDER	during most of wo )	rking	BAR	·
pu	be filed tal Hygie d other i	Bec	17. Father's Name (First, Middle, L	ast)			18. Mother's Na	me (First, Middle, M		
yla	2 should be and Mental is marked o	To	GEORGE H. SWEIT		*			ELLEN DON		
Maryland	コモトン		19a. Informant's Name/Relationsh ROBERT J. SWEIT			Mailing Address (Street a				ïp Code)
	1 an Heal em 2 ther		20a. Method of Disposition		20b. Place of	Disposition (Name of	1		Oc. Location - City or	Fown, State
OE	0		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from State pecify)	3	crematory or other place CHAEL'S CEM	.		ROSTBURG,	
Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service L	censue		22. Name and Addres			O W. MAIN	
_	20E # 9		Mariloy	111,00	wess	SOWERS FUN				MD 21532
v.	Physician		23a. Perf1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition		ed the death. Do no line. Lateral	Procum o		c or respiratory arre	st,	Approximate Interval Between Onset and Death
標	/Medical Examiner		resulting in death)	-	s a consequence o		ma			2 weeks
	Lxammer	1	Sequentially list conditions.	b	s a consequence o	n.				
_	uted J unsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua 10 (0; as	s a consequence o	).				
o,	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as	s a consequence of	):				
68760,	ficate be executed physician and is the burial-transit	edlcal		d						
		Med	IF FEMALE:	220 Hugo outcom						
.O. Box	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use a	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e or pregnancy 2 ☐ Fetal death at time of death	3 Ectopic pregnancy 5 Other (specify)		·	23d. Date of deliment	very Day Year
<u>α</u>	that the part of t		Part II. Other significant condition	ns contributing to death	but not resulting in	the underlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
of Vital Records,	w requires been sign should be	ed by	acrite R	enal F	orilux	2. hypox	2mia	1 Yes	s 2□No 3□Pro	bably 4 Unknown
eco	e law re has bee	ompleted	COPD an	nd emps	hysema	e hypoxi	_	24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
E		Con		1	đ			autopsy perform 1 Yes 2	ed death?	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		other 25 pos Othe		ath (Check only one		
oţ	Phys rrthis aral di	٠: To	1 ☐ Yes 2 12 No  27. Manger of Death	28a. Date of Inju	ent 2 ER/Outp	allent 3 DOA	4 Janursing H	lome 5 Resider	nce 6 Other (Spec	(hy)
ion	Attending I ir death. ector: After by the funer	atlor	1 Natural 5 Pending 2 Accident investiga	(Month, Da		ury Work	? ′es 2 □ No	203. 2000.100 110.	v Injury Godanou	
Division	el or Atten : after deat I Director: d in by the	ertification;	3 Suicide 6 Could no 4 Homicide determin	ned 289. Place of in	jury - At home, farr tc. (Specify)	n, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the best examiner: On the basis of and manner st	of examination and/	death occurred at the time for investigation, in my op	e, date and place inion, death occu	n, and due to the cau rred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier,	10		29c. License	number	296	d. Date signed (Month,	Day, Year)
			<b>&gt;</b> 2	1 Janually	m M D	DIC	+464	-	1/29/20	04
			30. Name and address of person w							
	Sta	to.	31. Date filed (Month, Day, Year)	S. L. Sandh	ir, M.D., rar's Signature			rostburg,	MD 21532	
-	Sta Registr		FL	B - 5 ZUU	from the state of	is boards	3			

		1 - Stata Ragistrar Ce		giene <sub>Reg. No.</sub> 2004 0335(
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  FRANCES BERTHA SCARLETT  4a. Facility Name (If not institution, give street and number)  AND AND AND AND AND AND AND AND AND AND	2. Date of Dei Month JANUAR  4b. City, Town, or Location of Death	Y 31, 2004 1:30P N 4c. County of Death
Funeral Director		ST VINCENT de PAUL NURSING CENTER  5. Social Security Number 217-10-7502  6. Sex 1 M 2/F 7. Age (In yrs. last birthday 98 Yrs.	FROSTBURG  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.  Month, De Jan 11,	ALLEGANY  9. Birthplace (State or Foreign PA)  1906  PA
Maryland -f show	tor	Usual Residence of Decedent		10d. Inside City Limit. 1 □ Yes 🔏 □ N
th with the 23e or 28e	Funeral Director	10e. Street and Number Box 195	26767	10g. Citizen of What Country? USA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes  No Specify:	Specify: white
within 72 ho iene. rthan "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12  Labore	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry  Textile
should be filed and Mental Hygis markad other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Walter Knight	18. Mother's Name (First, Middle, Annie V. (Hendi	rickson) Knight
and 2 sho ealth and I m 27 is mu		Clara Diehl daughter 577	ng Address (Street end Number or Rural Route Number of Hyndman Road Buffall sistion (Name of Date	or, City or Town, State, Zip Code) O Mills PA 15534
permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  **4 ☐ Donation 5 ☐ Other (Specify)**  **Cemetery, chi Prosperity U	ME Ch. Cemetery 2/3/2004  Name and Address of Facility Scarpelli Funeral Home, PA	Flintstone MD
/Medical Examiner of prijeting	Aedicai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshould or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Understanding Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	108 Virginia Avenue: Cumberl	
at the death cer by the attendir tached for use	hysician/N	in the past 12 gonths?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  9 ☐ Unknown	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
The lay ate has page 2	Completed by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the	1 🗆 1	prior to completion of cause of death?
Attending Physician: r death. ector: Afler this certific by the funeral director,	Certification: To Be C	25. Was case referred to medical examiner?  1	f 28c. Injury at Work?  M 1 Yes 2 No	dence 6 Other (Specify) now injury occurred  Street and Number or Rural Route Number,
Hospital or 24 hours afte Funeral Dir tely filled in	icai Cer	29a. Certifier 12 Certifying Physician: To the best of my knowledge, der (Check only 2 Medical Examiner: On the basis of examination and/or	h occurred at the time, date and place, and due to the vestigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
To the P within 2: To the I	Medical	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Typi	D36766	29d. Date signed (Month, Day, Year)  [Ebray 1, 2004
Sta Registr		DR. VIK POONAT 924 SETON DRIVE CUMB  31. Date filed (Month, Day, Yeer)  32. Registrar's Signature	CRLAND, MARYLAND 21502	

			For 1 - State Registrar	tate of Maryland		ent of Heal ate of Dea			giene 2001 Reg. No.	03351
			Decedent's Name (First, Middle, Last)				2.	Date of Dea		3. Time of Death
	Physicia /Medic		Hailey Louise S	irian				arlios		1 9:30 PM
	Examin		4a. Fecility Name (If not institution, give street		4b. C	City, Town, or Loca			4c. County of Dee	
		Н	Franklin Square		1 K	osed	Inder 24 Hrs. B	Date of Birth		more
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. la	Yrs. Mont		ours Min. 45 J	Date of Birth (Month, Day an. 23	, Year) C. 3. 2004 Man	thplace (State or Foreign buntry) .ULand
	_		Usuel Residence of Decedent				75 2	CC71. 23	,, 2007	
	trylan show	<b>.</b>	10a. State 10b. County	10c. City	, Town or Location	0.4.5				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	Directo	Maryland Baltimore			ultimore To Sodo			10g. Citizen of What Co	
	with the	Dire	10e. Street and Number 1 Lovelock Court		101.	. Zip Code 21	1236		U.S.A.	outiny:
	death with the Maryland ms 23a or 28a-f show	Funeral	11 Marital Status 12.	Was Decedent Ever in U.S	6. 13. Was D		ic Origin? (Specif exican, Puerto Ric	y Yes or No-		
·— 9	or iter	Fur	1 TV Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	1		exican, Pueπo Ric pecify:	an, etc.)		e, erc. Vhite
<i>iG</i> ; f 215-0036	within 72 hours after ene. than "natural", or ite	d by	3 Widowed 4 Divorced	Year or Dates:						
G ; 15-00	"natu	iete	15. Decedent's Educati (Specify only highest grade of	on ompleted)	16a. Decedent's ( Give kind o	Usual Occupation f work done during T use retired)	g most of working		16b. Kind of Business	Industry
b y	iene. iene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Infar				N/A	
4 6	other	BeC	17. Father's Name (First, Middle, Last)	·	-	18.			Maiden Sumame)	-
Bangyland	Mental Mental arked c	<b>To E</b>	Michael Holden		1				e Sirian	
Maryland	d 2 shoth thand had and the statement of		19a. Informant's Name/Relationship (Type, Mr. Robert Sirian (				Number or Rural F Baltime		r, City or Town, State, D 21236	Zip Code)
	f Heali f Heali item 2 other		20a. Method of Disposition	20b. PI	ace of Disposition of the company of		Date		20c. Location - City or	Town, State
الله حي	Page nent o int: If iry or		1 ☐ Burial 2 🂢 Cremation 3 ☐ Rem  1 ☐ Donation 5 ☐ Other (Specify)	ioval from State	view Cren		1/31/	04	Baltimore,	, Maryland
أرُرُرُ Saltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examples must be notified at once.		21. Signature of Funeral Service Licensee	ille			Facility Schir Rd., Ba		Funeral Hor e, MD 212:	
	K Ā		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	tions that caused the death	. Do not enter the	mode of dying, su	ch as cardiac or r	espiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Extreme	fremo	turn	<i>†</i>			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	I Tag	toma			
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ		1-2-1	210110	_		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	e exection and arrial-tr		resulting in death) Last	Due to (or as a consequ	ience of):					
8760,	cate be executed physicien and the burial-transit	dicai	d							
9	E 0 8		IF FEMALE: 23c.	If yes, outcome of pregna.	ncy				23d. Date of de	livery
Bo	leath certifi attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de	death 3 □Ectop	ric pregnancy r <i>(specify)</i>			Month	Day Year
o.	that the death ed by the atte detached for	hysi	9 Unknown	9□ Unknown						
Division of Vital Records, P.O. Box	or Attending Physician: The law requires that the death certift death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions contrib	buting to death but not resu	ulting in the underlyi	ng cause given in	Part I.		obacco use contribute t	o the cause of death?
oro	w requir been si should	Completed						24a. Was		
Rec	has b	mpi						autop , perfor	sy prior to death?	utopsy findings available completion of cause of
ta	ysician: The l is certificate ha director, page	e Co	25. Was case referred to medical			26.	Place of Death (		2 No 1 2 Yes	3 2 □ No
<u> </u>	ysicia is cert direct	To B	eyaminer?	pital: 1 Inpatient 2	ER/Outpatient 3	Other			lence 6 □Other (Spe	city)
0	ding Phys h. After this funeral di	L:uc	27. Manner of Death 1 Z Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe h	now injury occurred	
Sio	tendii leath. tor: A the fu	cati	2 Accident investigation	One Disease ( Initial At he	M	1 🗆 Yes		f Logation /6	Street and Number or A	ural Pouta Number
Divi	spital or Attenous after deat ours after deat neral Director: filled in by the	Certification;	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, rarm, street, ra	ctory, office	20	City or Tou		urar rioute realisor,
_	Hospita 4 hours Funeral	edical Co	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examiner	ian: To the best of my kno r: On the basis of examinal and manner stated.	wledge, death occu tion and/or investiga	rred at the time, d ation, in my opinio	ate and place, and n, death occurred	d due to the o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	POGER	5	29c. License nui	mber		29d. Date signed (Mon	
	⊢ š ⊢ ŏ			· hwo		Reso	00000		1-23-	2004
11			30. Name and address of person who comp	pleted cause of death (Item	23a) (Type, Print)				0 10	27
( M)			30. Name and address of person who comp Dr. Fonces Cor Rogers 31. Date filed (Month, Day, Year)	5 9000 Frank	lin sque	are Driv	le Bolt	IMO	e My 21-	3/
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  FR 0 5 2004	3 Registrar's Signa	ture de la conte					

**ORIGINAL** 

	State of Maryland / Department of Health an Certificate of Death	d Mental Hy	giene Reg. No 2	04 03353
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	eath Day	3. Time of Death
/Medical	James Leo Walsh	Jan 26		6:05am
Examiner	D I' ha ha ha ha ha ha ha ha ha ha ha ha ha		,	
	Devlin Manor Nursing Home  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Erland Hrs. 8. Date of Bi Vin. (Month, Da	Alleg	9. Birthplace (State or Foreign Country)
uneral irector	214-05-7057 1 Months Days Hours 1			
	Usual Residence of Decedent	- OG 2	1, 1908	MD
"netural", or items 23a or 28a-1 show edical Examinar must be notified at edical by Funeral Director	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
St Bar	MD Allegany Cumberland			X
Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Country?
ara la	507 Williams Street 21502	2 (Specify Voc of N		SA ce - American Indian,
by Funeral Director	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent to Hispanic Origin If Yes, specify Cuban, Mexican, P  1 □ Yes, Give 1 □ Yes 2 □ No If Xes, Give 1 □ Yes 2 □ Xo Specify:	erto Rican, etc.)	Specify	ck, White, etc. y:
a pe	\^^\!		16b. Kind of B	white usiness/Industry
of, the Medical	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	working		-
	Elementary/Secondary (0-12)  College (1-4or 5+)  Laborer		CSX Ra	ailroad
Be C		Name (First, Middle	, Maiden Surnan	ne)
ToE	Edward M. "Jim" Walsh Mary	Bauer W	'alsh	
other traumetic event, the M To Be Comp	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of	r Rural Route Numb	er, City or Town,	State, Zip Code)
	Rose Marie Walsh daughter 507 Williams Street	Cum	berland	MD 21502
	20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)	Date	20c. Location -	City or Town, State
once.	1 □ Agurial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify)  St. Mary's Cemetery	1/30/2004	Cumbe	erland MD
ouce.	21. Signature of Puneral Service Licensee 22. Name and Address of Facility			
8	Scarpelli Funera			24502
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or year failure. List only one cause on each fline.	diac or respiratory a	rrest,	Approximate
an	snock, or year failure. List only one cause on eacryline.			Intervel Between Onset and Death
al	Immediate Cause (Final disease or condition Cardio myo pathy			Means
er 🐇	Immediate Cause (Final disease or condition resulting in death)  e			
ne	Coronam Artem C	sease		years
Examiner				
ñ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Underlying			1
edical Examir	that initiated events resulting in death) Last  Due to (or as a consequence of):			
page z snould be detached for use a Completed by Physician/M				
should be detached for use a leted by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	tobacco use co	ntribute to the cause of death
Æ	myelodys plastic Syndrome	10	Yes 2 No	3 Probably 4 Unknow
β		CAL WAS	an autopsy	24b. Were autopsy findings
etec			ormed?	available prior to completion of cause
현				of death?
ပ္ပ		10	Yes ZXNo	1 ☐ Yes 2 ☐ No
To Be	examiner?	Death (Check only		
2	1   Yes 21700   1   Inpatient 2   ER/Outpatient 3   DOA   1   DOA	ng Home 5 ☐ Res	idence 6 Oth	
<u>o</u>	Natural 5 Pending (Month, Day Year) Injury Work?	280. Describe	now injury occur	180
Certification:	2 Accident investigation 3 Suicide 6 Could not be calculated by the could not be calculated by the calculation of the calculati	28f Location	Street and Numb	per or Rural Route Number,
Medical Certification: To Be Comp	4 Homicide determined building, etc. (Specify)		wn, State)	·
ျှ	29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	lace and due to the	cauca/s) and my	annot as stated
Medical	29a. Certifier (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	occurred et the time,	date and place,	and due to the cause(s)
Ž Ž	29b. Signature and title of certifier 29c. License number		29d. Date signe	d (Month, Day, Year)
ŭ		2614	1/2	0/20011
^	20 Name and address of parson who completed cause of death (Ham 33a) (Type Print)	77	1/2	12007
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
Ctoto	31. Diesus/of/appy, MarD. 32. Registrar's Signature Frostburg Pla	za Frostbi	urg MD 2	1532
State gistrar	FEB - 5 2004 \ Regue H Aparles'		_	
	the same of the sa			
6 Rev 6/95				

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			riease	State of Ma					•		_	)ie.	
			1 - For State Registrar	State of Ma		Departm Certific			Mental F	-	20	01.	0000
			Decedent's Name (First, Middle, L.	ast)		Ochine	ale or i	Dealit	2. Date of	Reg.	No. 💪 🔾	04	3. Time of Death
	Physici /Medi		Bertha Wilma Will	lard					Month	1100	~	Year 2004	9.450M
	Examir		4a. Facility Name (If not institution, gi	1 .	1,	4b. 0	City, Town, or	Location of De	eth	4	4c. County o		, ,
				edyNurs	sington	ne B	00N	Sbord	2		Was	hin	gton
	Funeral Director			Sex 7. Age	(In yrs. last birt	rrs. If U	ths Days	If Under 24 Hi Hours Mil	n. (Month,	Day, Ye	ar)	Countr	
7			Usual Residence of Decedent		00				Oct.	3, I	923	Tenne	ssee
Č	ahow ahow	_	10a. State 10b. County		10c. City, Town	or Location						10	d. Inside City Limits
Q	with the Maryland e or 28a-f show be notified at	ecto	Maryland Washingt	on	Boonsbo								1 ☐ Yes 2X No
_	with be or i	ā	10e. Street and Number  6 Blue Ridge Driv				Zip Code			10g.	Citizen of WI	hat Countr	у?
-	death	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.		1713	spanic Origin? (	Specify Yes or	US		- Americai	n Indian
ي ک	after or Its	Fu	1 Never Married 2 Married	Armed Forces?				spanic Origin? ( n, Mexican, Pue	rto Rican, etc.)	110		, White, et	
5-0036	hours a	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 40	s XXNo	Specify:			Specify:	Whit	e
5.	in 72	olete	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. i	Decedent's L	Jsual Occupa work done of	ation furing most of we	orking	16b.	Kind of Bus	iness/Indu	stry
2121	d within giene. r than	шо	Elementary/Secondary (0-12)	College (1-4or 5+	nur		T use retired,	,				e	1.
	be file tal Hyg d othe event,	BeC	17. Father's Name (First, Middle, Last	")	1	-		18. Mother's Na	ımə (First, Mide		rsing en Sumame,		IEA
₹	should b nd Ment marked matic e	To	James P. Smith				:	Finne C	. Smith				
o	permit. Fages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or Items 23e or any injury or other traumatic event, the Wedical Examinational Departs.	1 3	19a. Informant's Name/Relationship		19b.	Mailing Addr	ess (Street a	nd Number or F	lural Route Nur	nber, City	or Town, S	tate, Zip C	ode)
	1 and Healti em 27 ther t		William R. Willar 20a. Method of Disposition	d	6 B	lue Ri	ldge D	rive, Bo	onsbor				1713
70	Fages nent of int: If it iny or o		1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of I cemetery Mt. 01	crematory	or other place		Date		Location - C	•	
e イナト Baltimore,	nit. F partme oortan injur		*4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lies		ne. or			1	9/2004				aryland
36 <b>B</b>	permit. Departi		Ryan W. E	Seign M	00999	106 E	last Ch	urch St	reet i	nd Ba	astord	Fune	eral Home 21701
1			23a. Part 1. For the disease, or comshock, heart failure. List only	plication that caused the	ne death. Do no	ot enter the n	node of dying	, such as cardia	c or respiratory	arrest,	LICK	A	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	REC-	+AI		INO					Ö	Diset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of	):	1700	11: //					-
		P.	Sequentially list conditions,	b. Due to (or as a	consequence of	)·							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	000 10 (0) 232 1	consequence of	<i>)</i> ·							
98			resulting in death) Last	Due to (or as a	consequence of	):				-			
978	2 2 0	lical	(	d									
x 68	leath certificat attending phy I for use as the	Physician/Med	IF FEMALE:	00-11-									
Вох	atten for us	clan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tin	Fetal death	3 Ectopic					23d. Date of Month	,	ay Year
O.	that the de led by the a detached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ne or death	5 Other	(ѕреспу)						ly rout
G,	The law requires that the death certifica te has been signed by the attending phoage 2 should be detached for use as the	by P	Part II. Other significant conditions o	ontributing to death but i	not resulting in t	he underlying	g cause giver	in Part I.	23e. Dio	tobacco	use contribu	ute to the o	cause of death?
ord	w require been sig should b								10	Yes 2	2 □ No 3{	□ Probabi	ly 4 Munknown
ecc	law r	Completed							24a. Wa	s an opsy	24b. We	re autopsy	r findings available letion of cause of
<u>e</u>	ician: The lav certificate has rector, page 2								per 1 ☐ Yes	formed?	gea	th? Yes 2	
Vit		- □	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:			Other	26. Place of Dea					
of	g Physer this eral di	<u>ا</u> ر	27. Manner of Death	28a. Date of Injury (Month, Day Y	2 ER/Outp		DOA	4 Nursing F	lome 5 Res			Specify)	
ö	Attending r death. ector: After by the fune	atlo	1 Anatural 5 Pending 2 Accident investigation		e <i>ar)</i> Inju	iry M	28c. Injury a Work? 1 🔲 Ye	s 2 No	Lou. Dosonio	711011 111110	ny occurred		
Division of Vital Records, P.O.	r Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm	, street, facto	ory, office		28f. Location City or To	(Street a	nd Number o	or Rural Ro	oute Number,
Q	Hospital or 24 hours afte Funeral Dir tely filled in 1			- 1							,		
		Medical	29a. Certifier (Check only one)  Cartifying Ph 2 Madical Exam	ysician: To the best of n niner: On the basis of ex and manner state	annination and/o	leath occurre or investigation	ed at the time on, in my opir	, date and place	, and due to the	cause(s	and manne	or as state	d. e cause(s)
	To the within 2 To the Comple	Me	29b. Signature and title of certifier	· and manner stated	1.		9c. License r				ite signed (A		
	0		) Om					323		11	5>/	(56)	,
	,		30. Name and address of person who o							- '/	-//	24	
	0		Khalid M. Waseem, 31. Date filed (Month, Day, Year)		Leiter	sburg	Pike,	Hagers	town, M	ary1	and 2	21740	
	State Registra	~	FEB	32. Registrar's	Signature	AR 1	hours !	· •					
				10	10 mm 10 mm 10 mm	The same	March Same and Chicago						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Year 0 20 292004 /Medical January 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deat mac Tome MOCE If Under 24 Hrs. 8. Date of Birth A (Month, Day, If Under 1 Year 5. Social Security Number 6. Sex Z Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) -28-440 Hours 1 M 2 F Months Days Min Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or freme 23a or 28e-f show treumatic event, the Medical Examinar must be ricitified at 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 No Maryland 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No þ Specify: 3 Widowed 4 Divorced Specify: 'natural' Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 0 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked any injury or other treumatic evoluce. unk unk 19a. Informant's Name/Relationship (Type, Print) (daughter 19b. Mailing Address (*Street and Number of Rural Route Number, City o*r Avm. Gtato *Tip Code*) 4303 Clairidge St Philadelphia, PAvm. Gtato *Tip Code*) >.Karen 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 04/22/2004 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cremator 21. Signatur of Funeral Service License 22. Name and Address of Ficility L. Russ Joseph L. Ru Funeral Balto Ave 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** terminal Chronic disease or condition resulting in death) 15 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit to the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown 9 TUnknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direc 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

m.ar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

29c. License number

031865

Baetimre

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 6:00 p M **Physician** Janice Elizabeth Libbey Andrew February 1, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9613 Overlea Drive Rockville Montgomery 8. Date of Birth (Month, Day, Year) March 1, 1917 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2000F 86 Yrs. 050-16-5637 Director Usual Residence of Decedent death with the Marylend 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location i. Pages 1 and 2 should be filled within 72 hours after death with the Maryler riment of Health and Mental Hygiene.
rtent: if item 27 is marked other than "natural, or items 23a or 28e-f show jury or other treumatic event, if a Medical Examiner must be neithfied at jury or other treumatic event, if a Medical Examiner must be neithfied at 1 X X 2 No MD Montgomery Rockville Director 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number 9613 Overlea Drive 20850 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XYes 2 No If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: white Be Completed by 3 ☐ Widowed 4 ∑ ivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Library Librarian Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Nathaniel Libbey Frances Harding Libbey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12000 Mente Road, Manassas, VA Debra Davis, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD injury or Baltimore Crematory at LP ` 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility
Simple Tribute Funeral and Cremation Center
1040 Rockville Pike Rockville, MD <u>20852</u> 21. Signature of Funeral Service Licenses With 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 22 months **Physician** Esophageal cancer /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physicien for use as the buria Division of Vital Records, P.O. Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) sete has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed Was autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home XX Residence 6 Other (Specify) ٩ 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Medicai Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospitei 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43083 February 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. George Sotos 10605 Concord Street, Ste. 300 Kensington, MD 20895 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Genera to Apollo Registrar FEB 0 6 2004

DHMH 17 Rev 1/2001

**ORIGINAL** 

		1 - State Registrar			Ce	rtifica	nt of Health and te of Death		Reg. No.	_	
sici: edic		Decedent's Name (First, Middle     JOHN			ALD	ŖĮDG		2. Date of De Month	0 4	200	4 005
min	er	4a. Facility Name (If not institution,					, Town, or Location of Dea	ith	1	County of De	
16 te		North Arundel					n Burnie			nne Ar	
ral tor		5. Social Security Number 038–16–4986	6. Sex 1 <del>M</del> M 2 □	7. Age (In yrs.	Yrs.	Months	r 1 Year If Under 24 Hr. Days Hours Mir		y, Year)		irthplace (State or Fo Country) hode Islat
		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or L	ocation					10d. Inside City Li
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	Funeral Director	10e. Street and Number	munac		Deve		p Code		10g. Citi	izen of What C	Country?
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	ner	11. Marital Status	12. Was I	Decedent Ever in U	J.S. 13.	Was Dece	dent of Hispanic Origin? (scriy Cuban, Mexican, Pue	Specify Yes or No	)-		nerican Indian,
	F	1 ☐ Never Married 2 ☑ Marri	ed 1 □Y	es 2 No		1 Yes, spe		no nican, etc.)		Black, Wh	
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	ပိ	12	4)		Ser	geant		(C) . A		. Army	
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		19a. Informant's Name/Relationsh			1		s (Street and Number or F				
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	-	20a. Method of Disposition  1XXBurial 2 ☐ Cremation	3 Removal fr		Place of Disp cometery, cre	ematory or	other place)	Date	20c. Lo	ocation - City o	or Town, State
ė		*4 □Donation 5 □Other (Sp	ecify)	Ma	ryland			/2004		msvill	e, MD
once		21. Signature of Funeral Service I	icansan	_	2	Hard	nd Address of Facility esty Funeral	Home, F	.A.		
a		J.					idgely Avenu			, MD 2	1401
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ān		Immediate Cause (Final disease or condition		CORC				1	- >-		Onset and Deat
					11 / Land	· · · /_	WITTERY L	115017	26		1 . 30
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			1 - For State Registrar	Otato or mary as	Certificate of		Reg. No.	4 00000
			Decedent's Name (First, Middle,	Last)		2. Date o	of Death	3. Time of Death
	Physici /Medio		Alexander	G. Bro	wn Jr.	Feb	rugry 2201	04 12:55 1
	Examir		4a. Fecility Name (If not institution	give street and number)	: 4 / 1/ 1	or Location of Death	4c/ County of Dea	ith .
			Carroll	ounty HOS		If Under 24 Hrs. 8, Date of	of Birth 9 Bir	tholece (State or Foreign
	Funeral Director		5. Social Security Number 214 - 58 - 5047	6. Sex / 7. Age (In yrs	Yrs. Months Days	Hours Min. (Month		ountry)
2			Usual Residence of Decedent			T TOOK	70,1100111	J
A	laryian ehow	_	10a. State 10b. County	10c. C	City, Town or Location	1		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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X	death ms 23	era	11. Marital Status	12. Was Decedent Ever in I	U.S. 13. Was Decedent of I	Hispanic Origin? (Specify Yes o pan, Mexican, Puerto Rican, etc.	or No- 14. Race - Ame	
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$\frac{\sqrt{8}}{\sqrt{8}}$	should b nd Menti marked umatic e	To E	Alexander	G. Brown	Sr.	Kosalie	White	7.04
₩ SE	gas 1 and 2 should be filed within 72 hours after death with the Maryla ri of Health and Mental Hygiera is to thems 23a or 28a-1 ehov or other treumatic event, I a Medical Examinal must be notified at		19a. Informant's Name/Relationshi	ip (Type, Print) (Sister	19b. Mailing Address (Street	t and Number or Rural Route No	umber, City or Town, State,	Md 71744
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tre		20a. Method of Disposition	20b.	Place of Disposition (Name of	Date	20c. Location - City or	r Town, State
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Ö	be execution and the burial-transfer		resulting in death) Last	Due to (or as a conse	equence of):			
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B	atten for us	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fell	tal death 3 Ectopic pregnanc	;у	Month	Day Year
Ó	the d ached	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown				
Q.	s that	by P	Part II. Other significent condition	-			Did tobacco use contribute to	
grd	equire en si ould b	ted	ESPI)	· G	of bleeding		1 Yes 2 No 3 P	robably 4 Unknown
ec	alawr nasbe e 2 sh	nple	HTN	· A	hock Liver	bocy topeurs 24a.	Was an autopsy performed? 24b. Were a prior to death?	utopsy findings available completion of cause of
<u></u>	: The	S	<u> </u>	myofathy . S	JV Drug Hell	18C 10 Y	es 2 No 1 ☐ Yes	
	sician certifirecto	Be C	25. Was case referred to medical examiner?  1 Yes 2 Va No	Hospital: 1 Impatient 2	☐ ER/Outpatient 3☐ DOA Oth	26. Place of Death (Check of ther: 4 Nursing Home 5 1		ecifu)
0 5	inding Physician: ath. ir: After this certifice	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of lnjury Wo		ribe how injury occurred	
i	ath. or: Aft	atlo	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investiga	ation		Yes 2 No		
Division	or Atter ter de irecto n by th	Certification;	3 Suicide 6 Could no 4 Homicide determin	ot be ned 28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory, office cify)	28f. Location City or	ion (Street and Number or R r Town, State)	lural Route Number,
410	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1⊠ Certifying	Physician: To the best of my kr	nowledge, death occurred at the ti	ume date and place, and due to	the cause(s) and manner a	s stated.
	• Hos 24 hc • Fun	Medical		xaminer: On the basis of examinand manner stated.				
	within To th	Me	29b. Signature and title of certifier		29c. Licens	se number	29d. Date signed (Mon	th, Day, Year)
			* Uades	in MD	D-	005781	02/02	12004
	\	į	30. Name and address of person w	who completed cause of death (Ite	em 23a) (Type, Print)  ASKIN 197 FC	and Suite D	, Westnistu	MD 21157
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature			
	Regist	rar	FEB 0 6 2004	Dene	I sporks/			

		•	For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of H tificate of I	ealth and N Death		giene ()	04	03359
	Physici	an	1. Decedent's Name (First, Middle	Last)	2 12000	14-7-	_		2. Date of Dea Month		Year	3. Time of Death
	/Medic					V 6 1			January	<sup>Day</sup> , 20		4:15 PMM
	Examin	er	4a. Facility Name (If not institution Genesis Herita		umber)		Dundalk	Location of Death		4c. County	or Death Ltimo	ro
	Francis		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h		
	Funeral Director		117-20-3456	1 <b>⊠</b> M 2□F	76	Yrs.	Months Days	Hours Min.	Sept 4	1927	New	place (State or Foreign http:/ York
	P .		Usual Residence of Decedent		100.0	City, Town or Lo					1	IOd. Inside City Limits
	anylar show	اۃ	MD Balt	imore	100.0	Balti:					'	1 ☐ Yes 2√ No
	the M	ect	10e. Street and Number			- Darti	10f. Zip Code			10g. Citizen of V	What Cour	71
	with sa or	Funeral Director	103 Center Pi	lace			212	2.2				
	death ms 2:	Jera	11. Marital Status		cedent Ever in	U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Rac	SA e - Americ ck, White,	
36	rs after I', or Ite	by Fu	1 ☐ Never Married 2 🖔 Marr 3 ☐ Widowed 4 ☐ Divorced		2 □ No		1 □ Yes 21 No	Specify:	riican, etc.)	Specif	v· _	iite
Š	2 hou	ted	15. Deceden			16a, Dece	dent's Usual Occup	ation	ina	16b. Kind of B	usiness/In	dustry unk
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural; or Items 23a or 28a-f show aumatic event, it is Madical Examinar must be notified at	Completed	(Specify only highes Elementary/Secondary (0-12) 12		(1-4or 5+)		kind of work done of DO NOT use retired	during most of work ()	.mg			unk
2	filed Hygi other	BeC	17. Father's Name (First, Middle,	Last)		<u> </u>	CSPCISON	18. Mother's Nam	e (First, Middle,	Maiden Suman	ne)	
<u> a</u>	uld be Aenta rkad tic ev	To B	Wallace Fran	klin Barı	nett			Ella L	. Fenne	L		
ary	es 1 and 2 should b of Health and Ment f Item 27 is marked r other traumatic e		19a. Informant's Name/Relations				ng Address (Street				State, Zip	(Code)
2	and ealth m 27 her tr		Patsy Barnett/	spouse	Tooh		3 Center		ltimore, Date		222	- State
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation '4 💆 Donation 5 ☐ Other (S			cemetery, crei	natory or other place		Date	20c. Location -	City or 10	wn, State
Balt	permit. Departimports any inj		21. Signature of Euneral Service	icensee Wade	Vixegto	or S	Name and Addre tate Anat altimore,	ss of Facility Omy Board MD 2120	, 655 W.	Baltim	ore S	Street
		1	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that only one cause on			er the mode of dyin		or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	aDue to	o (or as a conse		NO					9
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	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Dun tr	c.  Due to (or as a consequence of):							
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ds, P.	ires that t signed by d be detai	ρ	Part II. Other significant condition	ons contributing to	death but not re	esulting in the u	nderlying cause giv	en in Part I.				he cause of death?
Division of Vital Records,	se law require has been si ge 2 should t	Completed							24a. Was autop	rmed?	prior to co death?	opsy findings available mpletion of cause of
a			25. Was case referred to medica					26. Place of Deat	1 Yes		1 🗆 Yes	2 □ No
5	Physician: rthis certifica ral director, I	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth		ome 5 Resid		er (Specif	v)
ı of	tending Physician: leath. tor: After this certific the funeral director,	ı.	27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time o			28d. Describe h			
Ö	Attending Isr death.	atio	1 Matural 5 Pendir 2 Accident investi	gation	,, ,,	,,		Yes 2 □ No				
Divis	= 00>	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined   200. Flat	ce of Injury - At Iding, etc. (Spe	home, farm, sti cify)	eet, factory, office		28f. Location (S City or Tow		er or Rura	al Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (		Examiner: On the			h occurred at the tin vestigation, in my o					
	To the complete complete the co	Me	29b. Signature and title of gertifie	attin	N		29c. Licens	23173 C		29d. Date signe		
-			30. Name and address of person			em 23a) (Type,	Dei-A\					
	Sta	at <u>e</u>	31. Date filed (Month, Day, Year)	1994	HA ( Registrar's Sig	dature	JEC,	247	ANNI	Trolis	s 1ct	MD 21227
	Regist		L F QUANT	- yum	means A	Los Jakon						

State of Maryland / Department of Health and Mental Hygiene 🤈 03360 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** EDITH GRACE BLOTTENBERGER February 03,2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1017 Grove Hill Road Baltimore Baltimore Co. Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 218-22-4422 74 Yrs Director March 21 1929 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination unit to natified at once. 1 ☐ Yes 2 ☑ No Baltimore Co. Baltimore Funeral Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1017 Grove Hill Road 21227 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lulie Elmer Lena Hesse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Blottenberger (Husband) 1017 Grove Hill Road, Baltimore, Md. 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 02/07/04 Baltimore, Md. 21. Signatury of Fernand Septice Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home p.A. 130 E. Fort Ave. Baltimore, Md. 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ances /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 110 completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 HO 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b Time of 28d. Describe how injury occurred After 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M death. investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Hospitel 1 Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) nd address of person who completed cause of death (Item 23a) (Type, Print) 10 40 Negl 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Marylar		ificate of		-	Reg. No.	14 03361
	Physic	ian	1. Decedent's Name (First, Middle, Las.	17	B	UTLE	R	2. Dete of De	ath Day Y	3. Time of Death
and the	/Medi Exami		4a Facility Neme (If not institution, give	street and number)	. 9		4b. City, Town, or	Location of Death	4	Death
7	LAdiiii	ilei	North Arundel H	lospital			Glen B	urnie	A.A	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birt		Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	81	Yrs.			6-4-1		ashington DC
	ylend		10a. State 10b. County	10c. Cit	ty, Town or Loca	ation				10d. Inside City Limits
	Ba-fal	ctor	MD A.A.	H	Ianovei	?				1 □ Yes 2X No
	vith th	Funeral Director	10e. Street end Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	eath y	erai	7234 Race Road	12. Was Decedent Ever in U	19 13 W	210		Proping Vos or No.	U.S.A	American Indian,
0	r then	F	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give	lf Y		dispanic Origin? (S an, Mexican, Puer	to Rican, etc.)		White, etc.
)02	72 hours effer death with the Marylend naturel', or flems 23a or 28a-f show after Evanding must be notified at	d by	3 ☐ Widowed 4 🌠 Divorced	If Yes, Give Year or Dates: WW I I	. 11	∐Yes 21X No	Specity:		Specify: ]	Black
21215-0020	natu	Completed by	15. Decedent's Edu (Specify only highest grad	lication le com <i>pleted)</i>	16e. Decede (Give ki	nt's Usual Occup nd of work done	pation during most of wo d)	rking	16b. Kind of Busin	iess/Industry
212	within ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		Emplo			U.S. Gov	r, 1 +
	be filed tal Hygi d other	Be Co	17. Fether's Name (First, Middle, Last)		1 00. 0	mp10	7		Maiden Surname)	v t
Maryland	should be nd Mental marked o	To E	Andrew Butler				Martha	Butle	r	
Mar	2 sho end ls me		19a. Informant's Name/Relationship (T)						er, City or Town, Sta	ite, Zip Code)
	1 and Health em 27 ther t		Jewel Butler (d		7234		d Hanov	ver MD	21076 20c. Location - Cit	a or Town State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryler Depertment of Health end Mental Hygiene. Important: If flem 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Evariant har notified at ance.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, crema	tory or other place. 11e Ve	2	2-10-04		ville MD
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	Physician /Medical		Immediate Cause (Final	Sentic	(	Hick				3 Ac. (
14	Examiner		disease or condition resulting in death)	a. Due to (c	or/as e conseque	ance of:-	1			squy)
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	the at	ysic	Part II. Other significant conditions cor	tributing to death but not resi	ulting in the unde	erlying cause giv	en in Part I.	23b. Did to	obacco use contrib	bute to the cause of death?
P.O.	res that the de signed by the a I be deteched I	F.						1 🗆 Y	es 2 No 3	☐ Probably 4 ☐ Unknown
Records,	v requires been sign should be	ed by						24a. Was a		4b. Were autopsy findings
000	aw recast bee	Completed						perfor	med?	available prior to completion of cause of death?
		Com						104	es 2 1 No	1 ☐ Yes 2 ☐ No
of Vital	Physician: Tripis certificel	Be	25. Was case referred to medical examiner?	lospital:		Oth		ath /Check only or	ne)	
of	this al di	5	1 Yes No	1 compatient 2 □	ER/Outpatient 28b. Time of	3□ DOA Oth	4LI Nuising n		ence 6 Other (S	Specify)
ion	Attending Forter death.  Ctor: After by the funer	혍	1 → atural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Worl M 1	k? Yes 2 □ No	203. 200.1100 11	ow injury occosined	
Division	or Attendil efter death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street	, factory, office		28f. Location (S. City or Town	treet and Number o n, State)	or Rural Route Number,
	To the Hospital or Atter within 24 hours efter de To the Funeral Direct completely filled in by the	al Ce	29a. Certifier 1 Certifying Phys	iclan: To the best of my know	wledge death or	ocurred at the time	ne date and place	and due to the a	auco(c) and marra	or ac stated
	n 24 h	edicai	(Check only one)	ner: On the basis of examinat and manner stated.	tion and/or inves	tigation, in my of	pinion, death occu	red at the time, d	ause(s) and manne late and place, and	due to the cause(s)
	To the within ?	ž	29b. Signature and title of certifier	- DI D		29c. License	e number	2	9d. Date signed (M	lonth, Day, Year)
	^		- alloy	May		PZ	-0094	1.00	2/05/0	4
	1		30. Name and address of person who co	mplete Lause of Seeth Mem	23a) (Type, Pri	nt) Par	K WALL	e Ne.	BUTHER	144 - 11
	Sta		31. Date filed (Month, Day, Year)	Registrar's Signar	ture		_ 12	1 ord	1111	- 42/0/
de.	Registr	ar .	0 6 200A	193 May 19	A 1944					

			1 - For Amend Item 10e State Registrar	f State	£828,782/0	08/0989 <i>Ce</i>	artment of Hertificate of I	lealth and M Death	1ental Hygi Re	iene g. No.	03362
	Physici	an	1. Decedent's Name (First, Middle, L	ast)	р	) voi za n+			2. Date of Death Month	n Day Yea	3. Time of Death
	/Medic	al	Lillian  4a. Facility Name (If not institution, gi			Bryant	4h Cihi Taua a	Location of Death	Feb	04 200	
	Examin	er	Good Samulition				Balt			4c. County of De	eatn
	Funeral		Social Security Number 6.	Sex	7. Age (In yrs.	last birthday	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		sirthplace (State or Foreign
	Director		212-36-2646	1□ M 2\\ F	80	Yrs.	Months Days	Hours Min.	8-1-23		N.C.
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or L	ocation				10d. Inside City Limits
	Maryl -f sho isd s	to	N1			. 7 4 4					t⊟Yes 2□No
	r 28a	Director	Md NA 10e. Street and Number			Baltimo	10f. Zip Code	0101/	10	g. Citizen of What	Country?
	th wit	ai D	6040 Harford Road 818 Winston Ave	nuo-			-2121	21214		USA	
	filed within 72 hours after death with the Maryland Hygiene. Wher than "naturel", or ttems 23a or 28a-f show with the Medical Examination must be codiffed at	Funerai	11. Marital Status	12. Was Dec Armed F		.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	nerican Indian, nite, etc.
5	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes If Yes, G Year or I	2 ☑ No ive X		1 ☐ Yes 2 No	Specify:		Specify:	Black
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Ž	thould d Mei mark metic	ပ္	19a. Informant's Name/Relationship	(Type Print)	ъгу	ant	ing Address (Street a		I Route Number		
2	lith an 27 is ritrau		Lossie Brown		ghter	1	Argonne I				
ກັ	s 1 a		20a. Method of Disposition		20b. F	Place of Disp	osition (Name of matory or other place	a) [	Date 2	Oc. Location - City	or Town, State
	Page nent c ant: If ary or		1 Donation 5 Other (Spec		State		Mem. Park	2-9-0	04 I	Randallst	own, Md.
Dall	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumetic event, the Medical Examination to other traumetic event, the Medical Examination to other traumetic event.		21. Signature of Funeral Service Lice	nsee L			2. Name and Addres	•		timore, M North Av	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that	caused the deat	_					Approximate Interval Between
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	LAdminer	_	Sequentially list conditions,	b. — Due to	(or as a conseq	uence off:					
	rted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Olssase or ir jury that initiated events	Due to	(or as a conseq	derice oi).					
,	execunary and ial-tra	Еха	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):					
Š	ficate be executed physician and s the burial-transit	edicai	•	_ d							
00	artifica ing ph e as th		IF FEMALE:								
	ath ce	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	tcome of pregna birth 2 Feta	Ideath 3	Ectopic pregnancy			23d. Date of d	elivery Day Year
į	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkn	nant at time of d	eath 5t	Other (specify)				
٠,	s that ned b e deta	by Pr	Part II. Other significant conditions	contributing to c	leath but not res	ulting in the u	inderlying cause give	n in Part I.	23e. Did toba	acco use contribute	to the cause of death?
"	quire an sig ruld b	ed b	Myocardial	Infar	ction	, Con	gestive.	healt	1 ☐ Yes	: 2□No 3□I	Probably 4 Denknown
ב כ	lawre as bee 2 sho	piet	failure, Dia	betis /	alle tu	s, Rem	al Insul	ficiency	24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
<u> </u>	The zate has page	Completed				,	N		perform	ed? death?	
	icien; sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Otho	26. Place of Death	(Check only one	)	
5	Phya r this ral dir	٦.	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date		ER/Outpaties 28b. Time of		4 □ Nursing Hor	ne 5 🗆 Residen 28d. Describe how	ce 6 Other (Sp	ecify)
5	ading th. : Afte s fune	Certification:	1 Natural 5 Pending 2 Accident investigation	(Mon	ith, Day Year)	Injury	Work	? ′es 2 □ No	20001100 1101	,	
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5	tel or rs afte al Dir ed in	Cert	4 LI Normoldo	Dalia	ing, etc. (Specif)				City or Town,	Siale)	
	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edicai	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	miner: On the b	e best of my kno easis of examina iner stated.	wledge, deat tion and/or in	h occurred at the tim evestigation, in my op	e, date and place, a inion, death occurre	and due to the cau ed at the time, dat	use(s) and manner a e and place, and du	as stated. e to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier		40		29c. License			d. Date signed (Mor	
			* Huft Stell	/	MD			5309		Feb, 04.	
	2		30. Name and address of person who Abdullah Kafao	completed cau	se of death (Item D Goo	d Sam	Print) Law H	ospital s	Tool Loe Baltimor	h Raven	Blud 21239
	Sta		31. Date filed (Month, Day, Year)	32. F	egistrar's Signa		P				
	Registr	alr	FEB 0 6 2	004	. * + m 0 . f	Silve Miles	4.2486.				

	G	For State Registrar			laryland i		artment of hartificate of	lealth and M Death		Reg. No.	004	0000
Dhyoisi		1. Decedent's Name (First,	Middle, Last)						2. Date of De. Month	ath Day	Year	3. Time of Death
Physicia /Medic				James	Dally		Coates,	Jr	2	1	2004	4:55p.
Examin		4a. Facility Name (If not ins	titution, give :	street and number	r)		4b. City, Town, o	or Location of Death		4c. Coun	ty of Death	1
		Sinai Hosp	ital				Baltin			N/	A	
Funeral		5. Social Security Number	6. Sex	( 7. A XM 2□F	Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birthp	place (State or Foreigntry)
Director		219-22-9488		AM ZUF	74	Yrs.				-1929		Md
2 >		Usual Residence of Deced			10c. City, T	own or La	antion					0d. Inside City Limits
aryla sho	_	Md	N/A			ltim						1 ∰Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mentalla Hygiene. Important: if Itam 27 is marked other than "natural", or itama 23a or 28a-f show amy injury or other traumatic avent, the Maryland Examiner mount be notified at any injury or other traumatic avent, the Maryland Examiner mount be notified at ange.	ecto									10g. Citizen o	L Maria Carre	
De d	ä	10e. Street and Number					10f. Zip Code			rog. Citizen o	r what Cour	itry ?
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E E	Funeral Director	11. Marital Status		12. Was Deceder Armed Forces	s?	13.	was Decedent or a If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	BI	ack, White,	
s aff	by F	1 ☐ Never Married 2( 3 ☐ Widowed 4 ☐ Dr		1 ☐ Yes 2√☐ If Yes, Give Year or Dates			1□Yes 2∏XNo	Specify:		Spec	ify:	Black
la maria	be		cedent's Edu	1000		6a Dece	dent's Usual Occup	nation		16b. Kind of	Business/In	dueto
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then the	E	Elementary/Secondary ( 6th gra		College (1-4o	n 5+) N / A		Rigger	-,		Drydo	-	0
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or of		17 Burial 2 ☐ Cren	ation 3 🗆 F		com	etery, crei	matory or other pla	ce)		ZOC. LOCATION	1 - Oity of To	JWII, State
men tant: jury		`4 Donation 5 □ O			King		orial Par			Randal.	lstown	ı, Md
permit Depar Impor Impor Once.		21. Signature of Funeral S	ervice Licens	00	,	2	2. Name and Addre	ess of Facility Mar				2121.
₹0 ₹ <b>a</b> d		Hum	NP	Tek	2			4300 Wa	and the state of t		Balti	nore, Md
		23a. Part . Enter the dise shock, or hear failur	ase, or comple. List only or	ications that caus ne cause on each	ed the death. I line.	Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
hysician	1	Immediate Cause (Final disease or condition		Congi	estine	1	leart :	Failure				Onset and Death
/Medical		resulting in death)			as a consequer				-			9:
xaminer		Conventially list condition		b								
	ner	Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury		Due to (or a	as a consequer	ice of):					- 31	
sician and burial-transit	Examiner	that initiated events		с.								
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it the death certificate by the attending phys tached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregn	ant 2	23c. If yes, outcom	ne of pregnancy 2 Fetal de		Textonio prognasa			23d. C	ate of delive	өгу
d for	Cla	in the past 12 month 1 ☐ Yes 2 ☐ No	s?	4□Pregnant	at time of deat		∃Ectopic pregnand ☐ Other (specify)	ту		, A	Month	Day Year
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fter o	E	4 Homicide	determined	building,	etc. (Specify)	e, rarm, st	reet, factory, office		City or To		n <i>ber</i> or mura	al Route Number,
within 24 hours after death.  To the Funeral Director: A completely filled in by the filled				1				1				
Lune ely fi	edical	(Check only 2 N	ertifying Phy edical Exam	iner: On the basis	s of examination	edge, dear n and/or ir	th occurred at the to execute the top of the	ime, date and place, opinion, death occur	and due to the red at the time,	date and place	manner as s e, and due t	stated. o the cause(s)
the Ipplet	Med	one)		and manner	stated.		1 00 11					
To Los	2	29b. Signature and title of		0011.1	MO			se number		29d. Date sign		
1	Ī	Stope	an y	sellul	1210		0	36885 veene 57		2/3/	04	
10		30. Name and address of	person who c	ompleted cause of		За) (Туре	Print)					
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,	1	77			istrar's Signal r	7	- S	100		4.11.00		

Jonathan Chester Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 0799State of Maryland / Department of Health and Mental Hygiene For State Registrar **AKG** Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 15:00P M 2004 January 29, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner IA Baltimore University Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 11-789 Months 10XM 2□ F Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28e-f ahov amy injury or other traumatic event, the Medical Examinar must be notified at once. 1 XYes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State eenmuunt (rematori 02.02.04 5 Other (Specify) 22. Name and Address of Ficility 21. Signature of Funeral Service Licensee theene Funeral Pike Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Wound a /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Year ίος Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. | be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 🔲 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \[ \subseteq \text{No} \] 24a. Was an autopsy page performed 2 No Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1XX es 2 No 1 Inpatient 2 RR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28b. Time of 1 Natural 5 Pending 28e. Place of Injury - At home, farm, str -et, factory, office building, etc. (Specify) Jnjury Cut X2 investigation within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 28f. Location Greet and Number or Rural Route Number, 3 Suicide filled in by 4 Homicide 228 8 Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (22) completely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. January 30, 2003 address of person who completed cause of death (Item 23a) (Type, Print) 7

Registrar

HOUDORE Milia 31. Date filed (Month, Day, Year) 32. Registrar's Signature

FFB Q 6 2004

111 Penn Street, Baltimore, Maryland 21201

		-	State of Maryland / Department of Healt 2/06/04 Jn 1- State RegistrarAMENMD ITEM #1,8826 PER PHY G828 2/Certificate of Dea	Ith and Mei		ene 2001	03365
			1. Decedent's Name (First, Middle, Last)		Date of Death	g. 140.	3. Time of Death
	Physicia		1.1.11		Month	Day Year	545 PM
	/Medic	al	4b. City, Town, or Local	ation of Ocean	2	3 Z D 4  4c. County of Death	
a.l	Examin	eı			0		
			7.01/11.15	Inder 24 Hrs. 8.	Date of Blab	132/tim	
	Funeral		Months Days Hou	ours Min.	(Month, Day,		place (State or Foreign intry)
	Director		171-19-1711		+2-3+-	t3 N5.	v york
	pu 🖈	-	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
	aryla sho	5					1 ☐ Yes 2 🖾 No
	88-f	ctc	Per yrand narrow		10	g. Citizen of What Cou	intar?
	ith th	Director	10e. Street and Number 10f. Zip Code 21040	`	10		and y :
	23a	rai	2027 naiisoii koad		V N -	USA 14. Race - Amer	ione Indian
	ems erm	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispani If Yes, specify Cuban, Me	exican, Puerto Ric	an, etc.)	Black, White	
စ္က	or li	Y.	1 ☐ Never Mamed 2 ☐ Marned 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Spe	pecify:		Specify: Wh	ite
ğ	ural'.	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:				
ν.	72 h	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)	g most of working	,	6b. Kind of Business/l	ndustry
7	ithin	du	Elementary/Secondary (0-12) College (1-4or 5+)			Own Home	
7	iled within 72 hours after deeth with the Maryland Hygiens. Hygiens than 'natural', or Items 23s or 28s-f show ther than 'natural', or Items 23s or 28s-f show ent, tra Medical Exaction must be notified at	S	12 Homemaker	Mother's Name (F	iret Middle M		
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S S	should be and Mental marked umatic ev	ပ္	National Colors				
Maryland 21215-0036	Cl ca = ca		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and N				
2	1 and 2 Health Iem 27 other tra		John T. Carson - Son 113 Patton Court	t, FOLSON		fornia 95  Oc. Location - City or 1	
Baltimore,	permit. Peges 1 and Department of Healt Important: If item 2 eny injury or other once.		20a. Method of Disposition  1 ☐ Burial 2   Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	!			
<u>Ē</u>	Peges ment of I ant: If its ury or o	-	4 □ Donation 5 □ Other (Specify) Hilltop Service Corp			Towson, M	
ä	Departr Departr Importa eny inje		21. Signature of Foneral Service Uicensee 22. Name and Address of F	Facility McCo	omas Fu	neral Home	, P.A.
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4.7			23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failute. List only one cause on each line.	uch as cardiac or r	espiratory arre	st,	Approximate Interval Between
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760,	eath certificate be executed attending physician and for use as the burial-transit	cal		ely mu	24 A	<b>少</b> ,	
68	ificat g ph) as th						
Вох	ndin use	N/U	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of deli	
	death certifica e attending ph ed for use as th	Icla	in the past 12 months?  4 Pregnant at time of death 5 Other (specify)			Month	Day Year
P.O.	that the do	Physician/Medi	9 Unknown		_		
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Re	The law ate has page 2	E G	- The fact of the period of th	2	autopsy	ed? death?	completion of cause of
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of Vital Records,	Physician: this certificated fra director, i	o Be	auaminar?			nce 6 Duller (Spec	me there to
of	Phys r this ral dir	<del> </del>	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at			w injury occurred	
O	or Attending after death. Director: After in by the fune	tou	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation (Month, Day Year) Injury Work?	200 A	Mily V.	hiele Acci	dent
:0	deat deat ctor: / the	lica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	- Y		eet and Number or Ru State)	
Division	or A after Dire	Certification:	4 Homicide building, etc. (Specify)			State)	
_	Hospitel 24 hours a Funerel I itely filled		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, da	date and place, an			stated.
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only one)  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License num	ımber	29	d. Date signed (Monti	n, Day, Year)
	ŏ -1 ≿ -1		1 12 120 - resident parsician Osolli	77 100		2/3/04	
	1.7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			, . ,	
	10		6730 TELLALS WAS HARRISBUTS PA 171	/// MIC	HAEL ORR	IS,MD.	
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				-
	Regist		EER 0 6 2004 Kanne K Angel				

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Certificate of Death	d Mental Hygiene 2004	0:
ast)	2. Date of Death Month Day Year	3. Tim

		For State Registrar	State of	Marylar	Cei	artmen <i>rtificat</i>	e of	ieaith a Death	and M	ental H	ygiene Reg. No.		1	03367
Dhuaisia		1. Decedent's Name (First, Middle, Las								2. Date of D		, Va	ar	3. Time of Death
Physicia /Medic		Walter Ray De	ming							ranuai	RY 3	Z, 20	1214	27:35 M
Examin		4a Facility Name (If not institution, give Saint Joseph	street and num. Medica	ber) il Cer	nter	4b. City,	Town, o	r Location o	of Death OWSC	יוו	4c.	County of D		imore
Funeral Director		5. Social Security Number 6. S 217–28–6847	ex 7 Mim 2□F	. Age (In yrs. 84	last birthday) Yrs.	If Under Months	1 Year Days	If Under a Hours	Min.	8. Date of B (Month, L July	irth Day, Year) 24, 1	919	Birthpla Count Ohio	ace (State or Foreign ry)
p .	-	Usual Residence of Decedent		10.0										
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th with th	Funeral Director	10e. Street and Number 11630 Glen Arm R	oad #Ull			10f. Zip		057				zen of Wha SA	t Count	ry?
the Helied within 72 hours after death with the Maryland tal Hygiene.  tal Hygiene.  d other than "natural", or Itame 23a or 28a-f show event, I're Modical Examiner must be notified at	by Funer	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1  Yes 2 If Yes, Give Year or Dat	es? ∑⊠No		Was Deced If Yes, spec		lispanic Orig an, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or N Rican, etc.)	lo-	14. Race - A Black, V Specify:	Vhite, e	tc.
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Hygi Hygi Int.		17. Father's Name (First, Middle, Last)			1	1111111	LSLE		r's Name	(First, Middl		relig:	lon	
2 should be and Mental is marked or sumatic even	To Be	Jarvis Deming							May	No11				
12 sh and ris n		19a. Informant's Name/Relationship (								l Route Num				Code)
and lealth mm 27	ļ.	Miriam Stockbri	age/spou		116	30 G1	en A	rm Ro		U11 G1				1057
permit. Peges 1 and 2 should be filed within Deportment of Health and Mental Hygiene. Important: if item 27 is marked other than eny injury or other traumatic event, Ira Magnes.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☑ Donation 5 ☐ Other (Specify	1)	tate	Place of Dispo cemetery, crer	matory or o	ne or ther plac	(e)	U	ate	20c. Lo	cation - City	or Tow	m, State
permit. Depertrimports ony inju		21. Signature of Funeral Service Licer	Wade Di	recto	r St	Name and attention of the second seco	nato	omy Bo	, pard 1201	655 W	Bal	timore	St	reet
Ve Design	1	23a. art1. Enter the disease, ir com	plications that ca	used the dea							arrest,			Approximate
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. MYOC	ARDIA	L INF	ARCT	ION							Interval Between Onset and Death
Examiner		Sequentially list conditions	CORO		ARTER	Y DI	SEA	5E						
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o	r as a consec	quence of):									
ificate be executed g physicien and as the burial-transit		resulting in death) Last	Due to (o	ras a consec	quence of):									
phys the	edical	•	d											
The law requires that the death certification has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		th 2 ☐ Feta nt at time of c	al death 3	Ectopic pr					2	3d. Date of Month		y Day Year
res that igned by be deta	by Ph	Part II. Other significant conditions of	ontributing to dea	ith but not res	sulting in the u	nderlying c	ause givi	en in Part I.				1		cause of death?
w requir been s	ted	LUNG_CAN	CER							1	Yes 2	QN0 3□	] Probal	bly 4 Unknown
The law r cate has be page 2 sh	Completed									per	opsy formed?	prior	to com	sy findings available pletion of cause of
	Ö .	25. Was case referred to medical						OS Diana	of Dooth	1 Yes		101	es 2	!Ll No
rysician: The	0 0	examiner? 1 ☐ Yes 2 Ø No	Hospital:	patient 2	ER/Outpatien	nt 3 DC	Othe	an.		(Check only ne 5□Res		· ·		
a Physical or this or all or	1	27. Manner of Death	28a. Date of (Month		28b. Time of		8c. Injun Worl			8d. Describe			респу)	
al or Attending Physician: after death. I Director: After this certific d in by the funeral director,	Certification;	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			Injury	, M	10	k? Yes 2 □ N	10					
- 255	Certif	4 Homicide determined	building	g, etc. (Speci						City or To	own, State)			Route Number,
To the Hospitel of within 24 hours at To the Funaral D completely filled in	edical	29a. Certifying Ph (Check only one) Certifying Ph 2 Medical Exam	ysician: To the base niner: On the base and manne	sis of examina	owledge, death ation and/or in	n occurred vestigation	at the tin	ne, date and pinion, deat	place, a h occurre	nd due to the	cause(s) , date and	and manner place, and	as stat	ted. he cause(s)
To the	Ň	29b. Signature and title of certifier				290	. License	e number			29d. Dat	signed (M	onth, D.	ay, Year)

29c. License number D 26587

29d. Date signed (Month, Day, Year)

30. Name and address o person who completed cause of death (Item 23a) (Type, Print)

ERIC TONER M.D. OSLER DETVE TOWNER, MARYLAND 7601 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

		1	For State Ragistrar	State of Maryland		rtment of He tificate of L			Jiene 2 leg. No.	004	03368
		_	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		Helen Deickman					Februar	у 1	2004	1.50 P. M
	Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or	Location of Death		4c. Cou	inty of Deeth	
			Frederick Villa Nur			Catonsy	ille			Baltim	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	Year)		lece (State or Foreign htry)
¥:	Director		216-32-8/31	89	115.			09/22/1	914	MD	
	and	-	Usuel Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	ation				1	0d. Inside City Limits
	Aaryl f eho	6	MD Baltimore		Wood	1 or m					1 ☐ Yes 2 No
	28a-	ect	10e. Street and Number		wood	10f. Zip Code			10g. Citizen	of What Cour	ntry?
	3a or	Funeral Director	106 Southland RD			2	21207			USA	
	Jeath TIS 2:	era		. Was Decedent Ever in U.S.	. 13. V	Vas Decedent of Hi Yes, specify Cuba		ecfy Yes or No	14.	Race - Americ Black, White,	
þ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If time 27 is marked other then "natural; or items 23a or 28a-f show any injury or other traumatic event. In Madical Examiner mant be notified at angle.		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Yes, specify Cubal	Specify:	rican, etc.)		ecify:	
3	urali,	d by	3 ⊠Widowed 4 □ Divorced	Year or Dates:					105 165-1	of Discipance/In	White
ņ	natu	Completed	15. Decedent's Educa (Specify only highest grade	completed)	(Give	ent's Usual Occupa kind of work done o OO NOT use retired	ation Mu <i>ring</i> most of work	ing	iob. Kina c	of Business/In-	uustiy
7	Athin hen	ш	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Nurs		/		Чос	ılth Ca	ro
7	ther ther out.		17. Father's Name (First, Middle, Last)		Nuls	IIIB	18. Mother's Nam	e (First, Middle,			16
/land	ntal h	Be	Bernard Callahan				Mary H.	Co1+			
Ž	d Me d Me mark matic	၉	19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailin	g Address (Street a			r, City or To	wn, State, Zip	Code)
<u> </u>	d 2 s th an 27 ls trau		Marion Ormiston/Fri		2029	Rudy Ser	ra DR E	ldersbu	no. Mr	21794	
ā,	Hea Hea tem		20a. Method of Disposition	20b. Pla	ice of Dispo	sition (Name of natory or other place		Date		ion - City or To	
<u> </u>	ages ent of nt: If i		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	moval from State	aina	Park Com	n2/n9	/2004	Balti	more.	MD
saltimore,	outer injur	1	21. Signature of Funeral Service Licenses		C22	Name and Address erling As 6 Edmonds	s of Facility	rah Fun	owol I	Iomo T	20
ñ	De grand		D. Carte	- Eva	73	6 Edmonds	son Ave.	Baltim	ore, N	$10^{11}2122$	8
31			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rest,		Interval Between
	Physician		Immediate Cause (Final disease or condition		54	whe					Onset and/Death
	/Medical		resulting in death)	Due to (or as a conseque	ence of):		( . (	0	A		<u></u>
	Examiner	L.	Sequentially list conditions, b.	ende	STAG	e A/2	herinen	1/2	ale	~	8 405
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque		as Sile	1	disen	~ 1		1111 00
	icate be executed physician and s the burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a conseque	ende of):	w Jul	vu	// 4			(09)
8760,	be ey										
287	phys phys s the	edical	a.								
ox	eath certific attending p for use as	Physiclan/Me	IF FEMALE: 23 23b. Was decedent pregpant 23	c. If yes, outcome of pregnan					23d	. Date of deliv	ery
ğ	atter d for u	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal : 4 ☐ Pregnant at time of de		]Ectopic pregnancy ] Other (specify)				Month	Day Year
o.	that the de led by the a detached f	nysi	9 Unknown	9□ Unknown							
<b>a.</b>	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Pi	Part II. Dther significant conditions conf	ributing to death but not resul	lting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
200	quires an sign uld be							1 🗆	Yes 20	lo 3∏Prol	bably 4 Unknown
Records,	s been si 2 should	Completed						24a. Was		4b. Were auto	opsy findings available ompletion of cause of
	The lav te has	mo						perfo 1  Yes	2 No	death?	2 □ No
Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	th Check onl			
	Physici this ce al direc	To B	examiner? 1 🗌 Yes 2 📉 No	ospital: 1 □ Inpatient 2 □ E	ER/Outpatier	nt 3 DOA Oth	er: 42 Nursing H	ome 5 Resi	dence 6	Other (Speci	fy)
0	Attending Physician: ir death. ector: After this certific by the funeral director,		27. Mann of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	k?	28d. Describe	how injury o	ccurred	
<u>Si</u>	andir sath. or: Af he fu	atle	2 Accident Investigation			M 1 🗆	Yes 2 □ No				
Division of	i or Attendater death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, st	eet, factory, office		28f. Location ( City or To		lumber or Hur	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Certifying Phys	ician: To the best of my know	vledoe dest	h occurred at the tir	ma, date and place	and due to the	causa(s) an	d manner as	stated.
	Hosi 24 ho Fund stely f	edical		ner: On the basis of examination and manner stated.							
	o the o the omple	Med	29b. Signature and title of certifie			29c. Licens	e number		29d. Date s	igned (Month,	Day, Year)
	F 3 F ŏ		<b> </b>     / /	m M	2014		297	69	2	13/1	24 ,
	0,	1 /	30. Name and address of person who	mpleted/causs of death (Item	a) (Type.	Print)	. / (	10 11	11	0 11	asl
	1	1	mariel-	). Albuen	no	60 5	(6 m. 1	Ellin	tol.	Bulk	2/228
	St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signat	ure	A			-		
	Regist	rar	0 6 2004	130 180 Son	57 160			•			

		1	For State Registrar	State	of Marylar		irtment of <i>tificate c</i>	f Health and I of Death		gienez ()	04	03369
			Decedent's Name (First, Middle, L.	ast)					2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia		Joseph George	DeGel	.e				Februar			10:25 AM
	/Medic Examin	_	4a. Fecility Name (If not institution, g.				4b. City, Tow	n, or Location of Death	)	4c. County	of Death	
	_ Admin	•	2110 Arden Dri	ve			Falls	ton		H	arfo	
	Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs.		If Under 1 Ye Months Da		8. Date of Birtl (Month, Da)	, Year)	9. Birthp	place (State or Foreign ntry)
	Director	l [	215-07-0706	<b>XX</b> M 2□ F	86	Yrs.		, i	May 22,			yland
	g ,	-	Usuel Residence of Decedent  10a. State 10b. County		10c. Gi	ty, Town or Lo	cation				1	10d. Inside City Limits
	sho	5		_								1 ☐ Yes 2√ No
	he M	Director	Maryland Harfo	ord		Falls	10f. Zip Cod	de		10g. Citizen of V	Vhat Cour	ntry?
	a or							1047			SA	•
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Madical Exeminer wast be notified a	Funeral	2110 Arden Driv		cedent Ever in U	J.S. 13. \	Vas Decedent	of Hispanic Origin? (S	pecify Yes or No-	14. Rac	e - Americ	can Indian,
	Item Iner	In I	1 ☐ Never Married 2 ☑ Married	Armed F		1	Yes, specify (	Cuban, Mexican, Puert	o Rican, etc.)	Blac	k, White,	etc.
99	urs af	b	3 Widowed 4 Divorced	If Yes, C Year or	aive **		I□Yes 2√x	No Specify:		Specify	· W	hite
ဝို	2 hou	Completed	15. Decedent's		41	16a. Deced	lent's Usual Oc	cupation one during most of wor	rkina	16b. Kind of Bu		
2	Pin 7	ple	(Specify only highest of Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use re	tired)	9			
7	giene giene er th	NO.	9			Dispa	atcher			Oil Co		У
Maryland 21215-0036	al Hy al Hy oth	Be (	17. Father's Name (First, Middle, La	st)				18. Mother's Nar	ne (First, Middle,			
Ja	Ment Ment arked	2	(unk) (unk)	(unk)				Carrie		Rimbac		
a L	2 sho and Is mu		19a. Informant's Name/Relationship					reet and Number or Ru				
≥	is 1 and 2 of Heeith a item 27 is		Marie A. DeGele	e / Wif		Towns to the same		Drive, Fal	Date	20c. Location -		
ore	iges 1 and 2 should be filed within 72 hours atler death with the Marylan it of Heelih and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, in a Marical Examination wat by notified at	١.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from	m State	Place of Dispo cemetery, crer	natory or other	place)				
Ē	Peges ment of I ant: If its ury or o		*4 □ Donation 5 □ Other (Spe	cify)	Ga	rdens o					ore,	Maryland
Baltimore,	permit. Peges 1 am Department of Heeli Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lic	Musi	d	2 <u>1</u>	ACCOMAS L317 Co	funeral H kesbury Ro	ome, P.A ad, Abin	gdon, M	aryla	and 21009
			23a. Parti Entey the disease, or co shock, or hear failure. List on Immediate Cause (Final	mplications tha ly one cause or	each line.	ith. Do not ent			or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	o (or as a conse		2.71001					2 years
ľ	Examiner				. (	,						
4		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due t	o (or as a consi	quenca ct):						
'	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c								
oʻ	exec an an rial-tr	Exa	resulting in death) Last	Due t	o (or as a conse	quence of):						
8760,	te be ysicig	dical		d								
9	tifical ng ph as th	edi										
Box	death certificate be executed e attending physician and of for use as the burial-transit	cian/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregree birth 2 Fet		Ectopic pregn	ancy			te of deliv	very Day Year
	ie deat the att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specif			MIC	11111	Day 1841
P.0	ac ac	Physi	9 Unknown						00. 814			the serves of death?
	uires tha signed I d be det	by	Part II. Other significant condition  Affly eros C			sulting in the u	nderlying caus	e given in Part I.				the cause of death?
pro	w requir been si should I		Myherosc	165021						Yes 2□No	3	bably 4 Unknown
of Vital Records,	law re as be 2 sh	ompieted							24a. Was autor	osv	prior to co	opsy findings available ompletion of cause of
Ä	The late has page	E							perfo 1 ☐ Yes	rmed? 2 No	death? 1 🗌 Yes	2 No
ital	ilcian: T certifical rector, p	BeC	25. Was case referred to medical					The state of the s	ath (Check only o			
<b>\</b>	S S S	2	examiner?	Hospital:	☐Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 Nursing H	lome 5 esi	dence 6 Oth	er (Speci	(fy)
			27. Manne death 1 Satural 5 □ Pending	28a. Da (M	te of Injury lonth, Day Year)	28b. Time of Injury		Injury at Work?	28d. Describe	how injury occur	red	
Ö	Attending r death. ector: Alte by the fune	atic	2 ☐ Accident investiga	4 ha				1 Yes 2 No				
Division		Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad   200, Fig	ace of Injury - At ilding, etc. (Spec	home, farm, st cify)	reet, factory, of	fice	28f. Location (. City or To		er or Rur	ral Route Number,
	itelo rsaft ral Di	Se										
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical	(Check only 2 Medical E	caminer: On the	basis of examin			he time, date and place my opinion, death occ				
	the thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and m	anner stated.			cense number		29d. Date signe		
	T Will		b signature and this or continue	1	1							
					/	00-1 /7	Print				/	, ,
	10		30. Name and address of person w	no completed c	ause of death (Ite	em 23a) (Type,	2 No	SOTA AV	re. Be	1 Air	, ma	1.21014.
	<u> </u>	o to	31. Date filed (Month, Day, Year)		Registrar's Sign							
	Regist	ate trar	FFR 0 6 2		England L	4 6	and the					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2:30 A. FEBRUARY 2004 VIRGINIA DAGUE SUSAN /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD MARINER HEALTH OF FOREST HILL FOREST HILL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June 17, 1 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2K F Yrs Maryland 1919 Director 220-10-7183 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23e or 28a-1 ahow any injury or other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event. 1 ☐ Yes 2 No Director Maryland | Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 USA 300 W. Ring Factory Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify. 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edith Owen Hardesty John Mark Hester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2928 Haddington Ct., Abingdon, Maryland 21009 William Blocher / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air, Maryland Mt. Zion U.M. Cemetery 2-5-04 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medlcal as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No has page 2 1 Yes 25 No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 ☐ No. 3 DOA 2 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 032259 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615W. Mac Brail DOV. I >< 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		For State Registrar	State of	f Marylan		artment <i>rtificate</i>			Mental H	lygien Reg. No	En U U T	03371
Physici	an	Decedent's Name (First, Middle, L.							2. Date of Month	Death Da	y Year	3. Time of Death
/Medic		Mary Exo Founta		wheel		4h City	Tour or	Location of Dea		- 1	3, 2004 County of Death	7:30 p
Examin	er	4a. Facility Name (If not institution, ga Genesis Elderca:			Ctr.	40. City,		Severna			Anne Arun	
Funeral	<i>y</i> .	Social Security Number 6.		7. Age (In yrs.		If Under Months		If Under 24 H	rs. 8. Date of			plece (State or Foreign
Director		054-12-3374	1□M 25€		85 Yrs.	Wionins	Juju	110010	Aug :	13, 1	918 Iow	**
and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
uth with the Marylan 23s or 28s-f show	ō	MD Anne A	rundel	Se	verna	Park						1 ☐ Yes 2 🗟 No
ith the M or 28a-1	Director	10e. Street and Number				10f. Zip	Code	<del>.</del>		10g. C	itizen of What Cou	intry?
23a o		24 Truckhouse Ro	ad			211	46			Un.	ited Stat	tes
after dez	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Worced	12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	2 110		Was Deced If Yes, spec 1 ☐ Yes 2	offy Cubar	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or erto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Whit	, etc.
72 hours	ted	15. Decedent's			16a. Dece	dent's Usua	I Occupa	ition uring most of w	nekina	16b. I	Kind of Business/fi	
21215-0 4 within 72 ho piene. r then *natur Ine Modical	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us	se retired,	)	iorking	Owr	n Home	
Net the		17 Caboda Nama (Simt Middle La	2		Home	maker		19 Mother's N	ame (First, Mid	dle Maide	n Sumame)	
Ore, Maryland 2121, jes 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other then "i	Be	17. Father's Name (First, Middle, Las George Exo	51)						Hocke	uio, ivialuo	n Sumame)	
hould Men mark	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a			mber, City	or Town, State, Zi	p Code)
Ma nd 2 s lith an 27 is r trau		Ms. Christine Fo		Daughte								
Baltimore, bermit. Pages 1 ar Department of Hea important: if item ony injury or othe		20a. Method of Disposition		20b. I	Place of Dispo	osition (Nan	ne of		Date		ocation - City or T	
Page Page nent o		1 ☐ Burial 2/☑Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		State	nesapea			1	Feb 7 2004	Bel	tsville,	MD
Baltimore, permit. Pages 1 a Department of He Important: If item eny injury or othe		21. Signature of Funeral Service Lic	ensee			2. Name an			neral A	1+orr	ativos	
<b>n</b> 88558		23a. Part1. Enter the disease, or co	W_	11009	040	8717	Gree	n Pastu	res_Dri	ve I	Baltimore	Approximate
Medical Examiner provided by the pring-transit the pring-transit provided by the principle by the pring-transit provided by the principle by the pri	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (	(or as a consector as	quence of):							
.O. Box 6 the death certific by the attending p ached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		ointh 2 ☐ Feta nant at time of	aldeath 3	⊒Ectopic pr □ Other (sp				_	23d. Date of delik Month	ver <b>y</b> Day Year
rds, P juires that n signed to	by	Part II. Other significant conditions	contributing to de	eath but not re	sulting in the u	underlying c	ause give	en in Part I.	1			the cause of death?
Division of Vital Records, to Atlanding Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be on the property of the funeral director, page 2 should be on the funeral director.	Completed								24a. W a p 1 \sum Ye	utopsy erformed?	prior to o death?	opsy findings availab ompletion of cause of 2 \( \text{No} \)
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Of Phys rat dii	5	1 Yes 2 No	28a. Date	of Injury	ER/Outpatie		28c. Injury Work	4 Divursing	· T · · · · · · · · · · · · · · · · · ·		6 □Other (Spec	ity)
On Con ding Fig. 1. After funer	ţ	1 Natural 5 Pending 2 Accident investigat	(Mon	th, Day Year)	Injury	М		(? Yes 2□No				
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To th within To the	Me	29b. Signature and title of certifier						number			ate signed (Month	
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4			NDRA	MD	300	5( 5	- h	IANO	JER S	7.	BACTIF	MORE 21
St Regist	ate	31. Date filed (Month, Day, Year)		Registrar's Sign	ature	de .	Lan	1				

DHMH 17 Rev 1/2001

Mary Exo Fountain 2/3/04 @ 7:30p

THOMAS A FORTUNATO Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-00726 1- For Unpend Item #23a, 27, 28a-f per me G828 2/10/14 tas Registrar Reg. No. DAP 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Thomas Α. Fortunato **Physician** JANUARY 26,2004 9:15 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8500 ANNAPOLIS ROAD NEW CARROLLTON PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1**√2** M 2□ F 72 084-24-4778 4, Director July 1931 NY Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State rel', or Itams 23a or 28a-f ehow Examiner must be notified at Orchard Park Erie NY 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 70 Southwick Drive 14127 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Tyes 2 □ No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify white 3 Widowed 4 Divorced "nsturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Efementary/Secondary (0-12) Coflege (1-4or 5+) Health CAre 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny jury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Be Thomas D. Fortunato Nina Vacanti 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Fortunato /Wife 70 Southwick Dr., Orchard Park 14127 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 3 Removal from State 1 Burial 2 Cremation Holy Cross Cemetery February 2, 2004 Lackawanna, 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 21. Signature of Funeral Service Lisense Victor P. Doda, Jr. 1501 Fast Fort Avenue Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or especially shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or especially shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or especially shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or especially shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or especially shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or especially shock, or heart failure. List only one caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** by cocaine intoxication /Medical Due to (or as a consequence of) **Examiner** Sequentiafly fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

| Very 2 | No has Yes 2 No Physician: 25. Was case referred to medicaf examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & Other (Specify) AT SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1XXYes 2 □ No Certification: To 28a. Date of Injury 1-26-04 (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 8:25 Jury 1 Natural 5 Pending 1 Yes 2 No investigation death 2 Accident found unknown Α the found Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number of Flural Royal Road City or Town, State) 8500 Annapolis Road 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide found in hotel room New Carrollton, Md (Ramada Inn) within 24 hours a 29a. Certifier 1 🗔 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 29c. License number 0 **OCME** JANUARY 27 ,2004 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) M. m. 111 Penn Street, Baltimore, Maryland 21201

Registrar

State

31. Date filed (Month, Day, Year) FEB 0 6 2004 32. Registrar's Signature

Sparks

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:30 AM M January 1, 2004 bettve 1-ishBein /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Ruxton of Pikesville Pikesville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 214-03-3538 94 Dec 14, 1909 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Heath and Mental hygiene. Itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. Le Mexical Examinar must be notified at 1 Yes 2 No MD Baltimore Pikesville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 Sudbrook Lane 21208 USA by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No white Specify 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 <u>housewife</u> own home Pages 1 and 2 should be filed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Meyer Cyrus Berman Eva Liebman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carrie Robbins/daughter 11 West 30th Street 15th flr New York, NY 10001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If Ita any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 \ Donation 5 Dother (Specify) 21. Signature of Fundal Service Licensee Konald S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 rector nous Approximate Interval Between Onset and Death 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock) or heart failure. List only one cause on each line. ONGESTIVE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** MONAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine Hospital or Attanding Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the causa of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, 1 Yes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Hospital: 1 ☐ Inpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death After 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funaral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1/2 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DZ3450 30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print), CHUNCH LA HY MID 5905 winner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

2:05 р.ш.

MARK FORREST

		For State Registrar	Sta	te of M	arylan	d / Depa	artment tificate					Reg. N	Scoreb Marie	04		
Physicia	n	Decedent's Name (First, Middle									2. Date of Month Febru		2, 200	Year		of Death
/Medica	al .	Mark Christian									Febru					РМ м
Examine	er	4a. Facility Name (If not institution					4b. City, T			of Death		4	lc. County o			
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Funeral Director		5. Social Security Number 212-94-6227	6. Sex 1 X M 2		35	last birthday) Yrs.		Days	Hours	Min.	8. Date of (Month, Apr 1	Day, Yea	968	COL	piace (Stati intry) :ylanc	e or Foreign
and w	-	Usual Residence of Decedent  10a. State 10b. County			10c. Cit	y, Town or Lo	cation								10d. Inside	City Limits
Many feb	ō	MD				Balti	more								1 <b>X</b> D Y	es 2 🗆 No
28a	Funeral Director	10e. Street and Number					10f. Zip	Code				10g. (	Citizen of W	/hat Cou	intry?	
3a or	譶│	3 Union Hall C	ourt					2	1228				USA			
death ms 2	Jera	11. Marital Status	12. Wa	s Decedent	Ever in U	.S. 13.	Was Decede f Yes, speci	ent of Hi	spanic Ori	igin? (Spe	cify Yes or	No-	14. Race		ican Indian	
or ite		1 Never Married 2 ☐ Marri	ed 1	Yes 2 X		i	Tes, speci		Specify:		rican, etc.,	,	Specify:		ite	
ours Frai.	d by	3 Widowed 4 Divorced	Ye	ar or Dates:			103 2	140	Opoury.				Зреспу.	WI	ITLE	
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Mithin ne. hen	du	Elementary/Secondary (0-12)	Co	llege (1-4or	5+)	ł	uter									
itied within 72 hours after death with the Maryland Hygiene. kther than "natural", or Items 23a or 28a-f ehow kther than Medical Exanda act must be notified at	ပိ	17. Father's Name (First, Middle,				Comp	uter	urar		er's Name	(First, Mic	idle. Maid	en Sumame	a)	<del></del>	
ntal h	Be	Carroll Wayn		est									Gill			
hould d Me mark matic	ဥ	19a. Informant's Name/Relationsh				19h Mailir	ng Address	(Street a							n Code)	
d 2 s th an 7 is r traur	- 1	Delores Forrre			er		ion H								p 0000)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational perceiting at once.		20a. Method of Disposition	30,000	pinoem	20b. F	Place of Dispo	sition (Nam	e of		the second second	ate	-	Location -		own, State	
ages int of t: If it		1 ☐ Burial 2 ☐ Cremation 4 ፟ Donation 5 ☐ Other (S)		al from State	·   °	emetery, crer	natory or of	her place	9)							
artme orten injury		21. Signature of Funeral Service			/	22	. Name and	d Addres	s of Facilit	ty						
permi Depa impo any i		Ronald S	. Wad	Dia	ector	St	ate A	nato	omy B	oard.	655 1	₩. Ва	ltimo	re s	Stree	t
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	- 1	shock, or heart failure. List Immediate Cause (Final	only one cau	se on each i	ine.										Interval I Onset ar	setween nd Death
Physician /Medical		disease or condition resulting in death)		RECTAL  Due to (or as		TI POSTOCIO								-		
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dea death	Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	40	☐Pregnant a ☐Unknown			Other (spe		<del></del>			_	Mon	ıtrı	Day	Year
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or At after d Direct in by	Certification:	4 Homicide determ	ined 286	building, e	tc. <i>(Specil</i>	ome, farm, str fy)	eet, factory,	office			City or	Town, Sta	and Numbe ate)	or or Hui	ai Houte N	umber,
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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier 1 Certifyin (Check only one)	Examiner: O	n the basis of manners	of examina	owiedge, deat ation and/or in	vestigation,	in my op	ie, date an pinion, dea	nd place, ath occurr	and due to ed at the tir	ne, date a	(s) and mar nd place, a	nd due	stated. to the caus	e(s)
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or Temporal	_		orl						377	7			71:	7/10	U	
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		30. Name and address of person						D.	ттио	MITIMA	MD	21001				
Sta	to.	DR. TARIQ MAI  31. Date filed (Month, Day, Year)	TUOOD	32. <u>Begist</u>		NEY VAI	TEX F	Ψ.	TIMU	MULUM	, MD	Z1093	)			
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			State of Maryland / Department of Health and Nature Registrar State of Department of Health and Nature Registrar Certificate of Death	Mental Hy	/giene 2004 03375
	Dhuaiai		1. Decedent's Name (First, Middle, Last)	2. Date of De	
	Physicia /Medic		James Fitz Gerald	01	30 2004 1/05 M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Deeth
			5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs.	8. Date of Bir	Anne Arandel
П	Funeral Director		218-03-3535 PM 2 F 92 Yrs. Months Days Hours Min.	0ct.30	ay, Year) Country)
			Usual Residence of Decedent	, 000.50	o, ioii viiginia
	nylan ihow	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Ba-fa	cto	Maryland Anne Arundel Pasadena	<del>"</del>	1 □ Yes 2 🗖 No
	with th	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
	s 23s	Funerai	1527 Palim Court 21122  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St	pacifu Vae or No	United States 0- 14. Race - American Indian,
	ter de	Fu	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1. Was Decedent of Hispanic Origin? (Signer Specific Cuban, Mexican, Puerto	o Rican, etc.)	Black, White, etc.
21215-0036	urs a	by	3 Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 No Specify:		Specify: White
2	72 ho	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	kina	16b. Kind of Business/Industry
7	ifthin be.	npie	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	3	Pentacostal Church
2	filed within 72 hours after death with the Maryland Hygiene. ther than 'natural', or items 23a or 28a-f show int, Ira Medical Examinat must be ricillised at	Ş	3 years ———— Minister  17. Father's Name (First, Middle, Last) 18. Mother's Nam	ne (Einst Middle	Penacosta' [ Church  a, Maiden Sumame)
anc	ntal h	Be			a d Ella Fitzgerald
Maryland	should nd Mer marke	J.	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru		<del></del>
S	and 2 sealth ar n 27 is		Barbara Butka (Grand.Dgt.) 1527 Palm Court, Pasa		
ē,	- I = =		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
Baltimore,	Pages nent of I int: If its iry or o		Meadowridge Mem Pk. 12-4-	2004	Elkridge, MD
aĦ	permit. Pag Department Important: I any injury o		21. Signature of Fugeral Service Licensee	ully- Pol	yniak Funeral Home
<u> </u>	89 = 9		moogii 3204 Mountian Road	Pasade	na, Mul ZIIZZ
To the second	Fnysician /Medical Examiner	her	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease contition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	ery ge	Approximate Interval Between Onset and Death
68760,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c. Due to (or as a consequence of):  d.	ill	Pire
P.O. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 NNo 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
	quires that en signed b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Age 92 hypertens.		tobacco use contribute to the cause of death? Yes 2 KNo 3 ☐ Probably 4 ☐Unknown
Division of Vital Records,	The law re ate has be page 2 sho	Completed	, t·	24a. Was auto perfo 1 - Yes	
/ita	cien: artific actor,	Be	25. Was case referred to medical examiner?	th (Check only	one)
of	Physithis aldır	2			idence 6 ☐Other (Specify) how injury occurred
L C	ding l	tion	1 □Natural 5 □ Pending (M., th, Day Yeer) Injury Work?	C W	now injuly occurred
S	Attendideath. ctor: A y the fu	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (	(Street and Number or Rury Route Number,
Ö	after after I Direct d in by	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or To	Annapolis Mo
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai C	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the rred at the time,	cause(s) and manner at stated.
	To the To the Comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
			Vallow D50059		131/04
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
	10	IJ.	medical orker to pli	40	21901
4	Sta Registi		31. Date filed (Month, Day, Year) 111 32. Registrar's Signature		

State of Maryland / Department of Health and Mental Hygiene 🤈 📋 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:20 A M Feb Charles Melvin Gardner 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Catonsville Baltimore Ridgeway Manor Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 16 1921 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1√2 M 2□ F 82 Maryland Director 218-07-9126 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28e-f show traumatic event, the Michigal Era cities in an action of the contract of the cont tX Yes 2 □ No Maryland n/a Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1616 Parkman Street 21230 United States death v Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then eny injury or other traumatic event, ITEM. Trucking Industry 10 Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Gardner Mary Reinhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean C. Gardner / Spouse 1616 Parkman Street, Baltimore, Maryland 21230 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 □ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Crest Lawn Gardens 2/6/2004 Marriottsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, of compelications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructure **Physician** izean disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Dualto for as a consequence off Examiner certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 9 🗀 Unknown been signed by I should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2X No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Yeer) To the Hospital or Attending Ph within 24 hours atter death. To the Funerel Director: Atter th completely tilled in by the tuneral tuneral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cegtifier 30. Name and address of person who dimpleted cause of death (Item 23a) (Type, Print) PINE MD e1 1001 G47 32. Registrar's agnature 31. Date filed (Month, Day, Year) State 0 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. Hours Min. ea Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) Year 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🕱 F -10-214 Director an Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a, State is marked other than "natural", or items 23s or 28s-1 show sumatic event, the Medical Examiner must be notified at Maryland 1 Yes 2 No Directo more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) omemake Hom e 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental porse 2 19a. Informant's Name/Relationship (Type, Print)/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) Department of Health a important: If item 27 is any injury or other trac 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Vicenses 22. Name and Address of Home Enter the disease, or complications that cause or heart failure. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially at accelling if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and physicien arts the burial-t Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been signed 2 should b 3 Probably 4 Dunknown 1 Tes 2 🗆 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an page certificate 1 ☐ Yes 2 PNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Medical Certification: To 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ esidence 6 ☐ Other (Specify) 2 No 3 DOA within 24 hours after death.

To the Funaral Diractor: After this completely filled in by the funeral dir 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner Leath 28b. Time of 1 Shitural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 4

Registrar
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32. Registrar's Signature

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

EUtall

31. Date filed (Month, Day, Year)

FEB 0 6 2004

State of Maryland / Department of Health and Mental Hygiene 🖓 🖺 🖟 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Delbert Gustafson January 15, 5:02 PMM 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State-off Preign Country) **Funeral** 1⊠M 2□F 536-05-7339 86 Jan 23, 1917 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show sny injury or other traumatic syent, the Medical Examinat must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Cecil Port Deposit 1 ☐ Yes 2√☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 101 Carlisle Drive 21904 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 12. Was Decedent Ever in U.S. Armed Forces? rried 1 Pes 2 No un 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Holy Cross Hospital 1500 Forest Glen Road Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 10 Other (Specify) in state of Ineral Service Licensee 21. Signatu State Anatomy Board 655 W. Baltimore Street Director monu 100 Baltimore, MD 21201 23a. Palm. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myocardial infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physiclen and ned for use as the burial-transit the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be 1 ☐ Yes 2 ☐ No 3 Probably Completed Deen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s this certificate 1 Yes 2 12 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 3 DOA 27. Man er of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Chinson D45285 January 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holy Cross Hosp 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 6 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 9:30P<sup>M</sup> February Carol Grace Ganjon 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City 11624 W. Winchester Lane Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖾 F Director 219-44-6569 58 June 10, 1945 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State rai', or items 23a or 28a-f show Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Howard Ellcott City the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 11624 W. Winchester Lane 21042 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 21X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced \*natural', Completed of Health and Mental Hygiene, itam 27 is marked other than "natur other treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+Physical Education Teacher 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 2 Ernest Bachman Carolyn Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Ganjon (Husband) 11624 W. Winchester Lane Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: If its any injury or of once. 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 2-6-2004 Lorraine Park Woodlawn, Maryland 21. Signature of Funeral Service Licensee permit. Vitzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228 yould Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition carcinoma, unknowntriman **Physician** metastatic resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the attending p as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown signed by 1 d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No s need s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy performed? page 2 No 1 Yes ≯ No 1 🗌 Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and of certifier 29c. License number 29d. Date signed (Month, Day, Year) 035254 Ĵ, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catonaro BALTMOREMD 21 229 Miller mo 9,00 anole 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 6 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 02/ **Physician** C. Honora Hart 01/ 2004 11:15am /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 220-03-4081 84 Sept. 30,1919 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show f Health and Mental Hygiene. Item 27 is marked other then "naturs!", or Items 23a or 28a-1 shov other traumatic svent, tra Madical Extrainment or notified at 1 Yes 2 □ No MD N/A Baltimore City Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1337 E. Clement Street 21230 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Martin Flynn Annie Barrett ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael M. Hart / Son 514 Pondarosa Drive, Belair Maryland 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ŏ NSBurial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery Feb. 5, 2004 Department (Important: If sny Injury or once. Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 21. Signar to of Fundral Service to Victor P. Doda, Jr. 1501 East Fort Avenue, Baltimore ,MD 21230 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause of each Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ell concinoma Immediate Cause (Final disease or condition resulting in death) year Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending physic IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death P.O. 1 been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s has certificate 1 Tes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 Yes 2 No Certification: To After this funeral d 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. Director: / d in by the fe 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title decertifier February 1, 2008 und who completed cause of deathy Item 23a) (Type, Print) 30. Name and address of person N. Charles St. Balto. md 2120x But 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004 6

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State of Maryland / Department of Health and Mental Hygiene
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Physic		1. Decedent's Name Carlos	e (First, Middle, L. Herrera	ast)					Mont	of Death	<sup>Day</sup> 31, 2	Yeer OO 4	3. Time of Death 10:39 PM
/Medi Exami		4a. Fecility Name (I	f not institution, gi				· ·	own, or Location of	of Death	IMAO	4c. County	of Deeth	
Funeral Director		5. Social Security N 070-46-2513	3	Sex 1 <del>M</del> 2 ☐ F	7. Age (In yrs 63	. last birthday) Yrs.	If Under 1 Months	Year If Under Days Hours	Min. (Mon	of Birth th, Day, Ye ary 29	,1941	9. Birthp Coun	plece (State or Foreigr htry) Ecuador
a-f show	ctor	Usual Residence of 10a. State NY	10b. County	eens	10c. C	ity, Town or Lo	cation ast Elm	nurst				1	0d. Inside City Limits
hours after death with the Maryland tural, or tleme 23e or 28e-f show at Exeminer must be notitied at	al Director	10e. Street and Nur 92–12 25	oth Street				10f. Zip C	ode 11369	7	10g.	Citizen of V	Vhat Coun	try?
utal Hygiene. nd other than "natural", or itema 23a or 28a-f show event, the Mudical Examinat must be notified at	by Funeral	11. Marital Status  1 Never Marri 3 Widowed	ed 35 Married 4 Divorced	12. Was Dec Armed Fo 1  Yes If Yes, Gr Year or D	ANNO ve				gin? (Specify Yes n, Puerto Rican, et Rquadoria			e - Americ k, White,	
r than "natur Iba Mudical	Completed	(Spec	15. Decedent's E ify only highest gr ndary (0-12)	ducation ade completed) College (		(Give	lent's Usual ( kind of work DO NOT use Labor	done during mosi retired)	t of working	16b	. Kind of Bu		,
Is marked other than raumatic event, the Mu	To Be C	17. Father's Name (	o Herrera	"				Tere	er's Name (First, M Sa Leonore	Rodrig	den Sumam JUEZ	Θ)	
f Health and Men Item 27 is marke other traumatic		19a. Informant's Na Irasema	Herrera /						er or Rural Route A East Elmhur			State, Zip	Code)
Department of Health Important: If Item 27 eny injury or other tr QDCE.		<sup>¹</sup> 4 □ Donation	☐Cremation 3√ 5 ☐Other (Speci	fy)	State Mt.	Place of Dispo cemetery, cren • Hope Os	natory or other	er place)	Date y 6, 2004		Location - C	-	wn, Stete Son, NY
Department of Himportant: If Ite eny injury or of QDCE.		21. Signature of Fu	neral Service Lice	Victor	P. Doda,	- u	Name and A parles I 01 Fast	Address of Facility  Stevens  Fort Aver	Funeral Ho nue, Baltin	me, In	) 2123	n	
ysician Medical aminer transit	Examiner	23a. Par1. Enter it shock, or hear immediate Cause (disease or condition resulting in death)  Sequentially list conif any, leading to imcause. Enter Under Cause (Disease or that initiated events resulting in death).	Final n ditions, mediate rying n jury	b. Due to	aused the dealeach line.  Mish of the consection	quence of):		of dying, such as		ory arrest,			Approximate Interval Between Onset and Death
tached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12. 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		einth 2 Feta ant at time of c	al death 3 🗌	Ectopic pregi Other (speci				23d. Date	of deliver	ry Day Year
signed d be de	by	Part II. Dther signifi	cant conditions	contributing to de	eath but not res	sulting in the un	derlying caus	se given in Part I.			V		e cause of death?
ate has	Completed									Was an autopsy performed?	pr	rior to com eath?	sy findings available pletion of cause of
Pnysician: The rithis certificate ral director, pag	To Be	25. Was case referrexaminer?		Hospital:	noatient 2	ER/Outpatient	3 🗆 🗅 🗅 🗛	045	of Death (Check o		. P		
Afte fune	Certification: T	27. Manner of Death 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending investigation 6 Could not b	28a. Date of (Month	of Injury th, Day Year) -31-04	28b. Time of Injury	P <sub>M</sub> 28c.	Injury at Work? 1 Yes 2 N	lo Sub	ibe how in	jury occurre	shot	
in Sie		4 X Homicide	determined	buildir	ng, etc. (Specif	Roa	d		Frank	Town, Sta	un 470	00 BI	Baltimore mi
To the Hospital within 24 hours a To the Funeral [ completely filled	Medical	(Check only one)	Medical Exer	niner: On the ba and mann	asis of examina	wiedge, death ttion and/or invi	occurred at t estigation, in	ne time, date and my opinion, death	place, and due to h occurred at the ti	the cause( me, date a	(s) and man nd place, ar	ner as sta nd due to t	ted. :he cause(s)
Tol	Σ	29b. Signature and t	itle of certifier	mis	>			cense number			ate signed		
/			)				0	_ 11 F1		1.17	UNUAN.	<b> ,</b>	~UU-1

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LING LI. MID

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath Month Yaar Physician MIL DRED 3: 15 AM JAN P005 /Medical 4b. City, Town, or Locetion of Daath 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Genesis Randallstown Randallstown Baltimore If Undar 1 Year If Under 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) **Funeral** Days Hours Months Yrs. 213-38-9468 75 Mar 1, 1928 Director North Carolina Usuat Rasidence of Decedent 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location MD 1 ☐ Yas 2X☐ No Baltimore Randallstown Completed by Funeral Director 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 21133 USA 9109 Liberty Road 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Datas: Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. unk 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or item eny injury or other treumatic event, the Medical Examina. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: black 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) domestic worker private homes 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Mollie Hayes 2 19b. Mailing Address (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Willie Seacy/nephew 150 Elsing Green Way Highland, VA 23075 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 🖾 Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade, 22. Nama and Addrass of Facility State Anatomy Board 655 W. Baltimore Streat and 21201 Baltimore, MD 23a. Part. Entar the disease, or emplications that exist data death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, show, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Death Physician /Medical Immediata Causa (Final disaasa or condition rasulting in death) PANCREATIC CARCINOM Examine Physician/Medical Examiner ARTERY ORONARY DISEATE physician and s the buriel-trensit To the Hospital or Attanding Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: Atten this certificate hes been signed by the attending physician and completely filled in by the Inneatal investion, page 2 should be deteched for use as the burleast Sequentially list conditions, if any, leading to immediata ceusa. Entar Underlying Causa (Disaase or injury that initiated events Dua to (or as a consaquance of) Records, P.O. Box 68760, HYPERTEN SION Dua to (or as a consaquanca of): rasulting in death) Last 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformad? TUYES ZENO 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spacify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medicai Certification: To 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of Division 5 Pending 1 Natural 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be detarmined 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 3 ☐ Suicide 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) 4 - Homicide Fortifying Physician: To tha bast of my knowledga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 29a. Cartifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifier 29c. Licansa number Syrohe DO053150 JAN 1500 2004 30. Nama and address of person who completed causa of death (Itam 23a) (Typa, Print) 201-109 BACURIVERNECL GUPTA SHALLUNMALA 32. Ragistrar's Signatura 31. Data filed (Month, Day, Year) BALTIMONE ZIZZI State

DHMH 16 Rev 6/95

Registrar

FEB 0 6 2004

ORIGINAL

			for State Registrar	State of N	/laryland		artment <i>tificate</i>					giene Rog. No.	200	03380
45	Physici	on.	1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea	ıth	Year	3. Time of Death
	/Medic		Nancy Lee House								Februar			1:00 p M
7	Examir	ner	4a. Fecility Name (If not institution, give Casey House	street and numbe	r)		4b. City, T Rock			of Death	th 4c. County of Death  Montgomery			
J.S.	Funeral		Social Security Number 6. S	9X 7. A	Age (In yrs. Ia	ast birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Birth			
b	Director		521-46-7543	□M 2∏F	64	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day May 23,	193	39 8	ountry) Colorado
	and w		Usuel Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Maryl -f sho	tor	MD Monts	gomery	1 '	aither								MXYes 2 □ No
	h the or 28a s rotti	irec	10e. Street and Number		1		10f. Zip (	ode				log. Citiz	zen of What C	ountry?
	23a c	Funeral Director	76 West Deer Par	rk Drive			20	877				Ur	nited S	States
	er dez Itams	nue	11. Marital Status	12. Was Deceder Armed Forces	?	S. 13. V	Vas Decede Yes, specif	nt of His y Cuban	panic Orig	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	1	4. Race - Am Black, Wh	
336	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28a-f show the Modeul Exertinar traist be rediffed at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2X If Yes, Give Year or Dates		1	□Yes 2	χNο	Specify:				Specify:	white
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2	ithin 796.	npie	Elementary/Secondary (0-12)	College (1-4o	r 5+)		kind of work OO NOT use			or workir	ng	Dep	ot. of	Health and
2	Hygier Hygier ther tl		17. Father's Name (First, Middle, Last)	1		Sta	ff Ass			r's Namo	(First, Middle,			rvices
and	d be d ental i	To Be	Richard Lee Hous	se							ae Curr			
Maryland 21215-0036	shou ind M ind M i mari	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (	Street ar			Route Number			Zip Code)
Ž	and 2 salth a n 27 is		Lynne Peterson, Da	ughter		1348	12th	Str	eet,		on, Iow		2302	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23e or 28e-f show any injury or other traumatic avent, the Modical Exactly and read be notified at anotes.		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐	Removal from State	20b. Pla	ace of Dispos metery, crem	sition (Name natory or oth	of er place	) 2	:/3/8	4		ation - City or	
Ħ	t. Partmen		* 4 □ Donation 5 □ Other (Specify	2	Balt	imore			1				imore,	
Ba	Depa Impo any in		21. Signature of Frineral Service Lice	40	Vas		LU4U R	ockv	ville	Pik	e Rockv	ille	ematio , MD	n Center 20852
p.		4		Approximate Interval Between Onset and Death										
>	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Metast			Cancer							Months
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	icate be executed physician and s the burial-transit	Examiner	that initiated events	c										
60,	be execian a		resulting in death) Last	Due to (or a	s a conseque	ence of):								
98760	physicate I	dicai		d									-	
Box	death certifi e attending I id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								2:	3d. Date of de	livery
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	: The law cate has I , page 2 s	Con									perforr	ned?	death? 1 ☐ Yes	
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UIVISION		Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	njury - At hom etc. <i>(Specify)</i>	ne, farm, stre	et, factory, o	office		2	8f. Location (St. City or Town	reet and , State)	Number or R	ural Route Number,
_	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	edical C	29a. Certifier 1 X Kertifying Phy (Check only ann) 2 Medical Exem	iner: On the basis of	of examinatio	rledge, death on and/or invi	occurred at	the time	, date and	place, ar	nd due to the ca	ause(s) a	ind manner as	s stated.
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•	r s r ō		Colletter.	En					41:	2 / 0		12/	00/5	)//
	1 0		30. Name and address of person who c			23a) (Type, F	Print)		-/ 12-	~ 18		L/C	12/0	7
	12		Dr. Charles Harr				ter M	i11	Road	, Roc	ckville	, MD	2085	2
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			For State	State of Ma	aryland /		artment of H <i>tificate of I</i>				giene Rea. No.	Em 7 (1 , 1)	03384
			Registrar  1. Decedent's Name (First, Middle, Las	it)						Date of De	ath		3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location				County of Death	1
	LAGIIII	٠.	906 Wesley Road				Rockvil	.1e				ontgomei	4
	Funeral		Social Security Number 6. S		e (In yrs. last		If Under 1 Year Months Days	If Under Hours	Min. 8.	Date of Bir (Month, Da	th y, Year)		place (State or Foreign intry)
	Director	ļ	212-76-7970	<b>X</b> ) M 2□ F	46_	Yrs.			J	une 2	2, 1	957 Hav	waii
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, T	own or Lo	cation		· · · · · · · · · · · · · · · · · · ·				10d. Inside City Limits
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	the the	Director	Maryland   Montgome	sı y	RO	CRVI	10f. Zip Code				10g. Citi	izen of What Cou	intry?
	3a o	<u>=</u>	906 Wesley Road				2	0850			Uni	ted Stat	es
	death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Decedent of H f Yes, specify Cuba	ispanic Or	rigin? (Specif	y Yes or No	>-	14. Race - Amer Black, White	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or iteme 23a or 28a-f show important: If term 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, Ita Maulcal Examinar mant be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 Yes 2 1 1 If Yes, Give Year or Dates:	No	1	1 ☐ Yes 2 🙀 No	Specify				Specify: Wh	ite
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7	d with	E O	12	College (1-401 2	A	utom	otive Mec					Automoti	ve
2	othe vent,	ВеС	17. Father's Name (First, Middle, Last)					18. Moth	ier's Name (F	First, Middle	, Maiden	Sumame)	
<u> </u>	Ments Ments arked	2	Clare Eugene Hall		1				Mae F				201
8	and and te m		19a. tnformant's Name/Relationship (				ng Address (Street						ip Code)
2	and fealth im 27 her to		Doreen Decker/Pers	sonal Rep.			Wesley Ro		KOCKV1			J85U ecation - City or 1	Town, State
5	iges it of the		1 X Burial 2 Cremation 3				sition (Name of matory or other place						
	it. Partmer		<ul> <li>4 □ Donation 5 □ Other (Specif</li> <li>21. Signature of Funeral Service Licer</li> </ul>		Gate		Heaven Name and Addre		02/05/ lity			lver Spr	
ם מ	Depar Depar Impo any ir		Muthy.	Do My		10	Name and Addre imple Tri 040 Rocky	<u>ille</u>	Pike;	Rock	ville	emation e, MD 20	Center 1852
	7,91		23a. Part1. Enter the disease, or com shock, or heert failure. List only	plications that caused one cause on each li	the death. I	Do not ent	er the mode of dyin	ig, such as	s cardiac or re	espiratory a	rrest.		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. Gastri	c Carc	inom	a						8 Months
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	nce of):							
	0	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequen	nce of):							
	nsit	Examiner	Cause (Disease or injury										
<u>-</u>	exectin and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as	a consequen	nce of):							
0000	icate be executed physician and s the burial-transit	dicai		d									
0		0	IF FEMALE:									1.	
200	law requires that the death certifi as been signed by the attending r.2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetet de	eath 3	Ectopic pregnancy	1				23d. Date of detine Month	very Day Year
	the a	ysic	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of deat	n sc	Other (specify) _						
7.	that the ed by detact		Part II. Other significant conditions	contributing to death b	out not resultir	ng in the u	nderlying cause giv	en in Part	I.	23e. Did	tobacco u	use contribute to	the cause of death?
necoras,	uires sign d be	d by								1 🗆	Yes 2	X No 3 □ Pro	obably 4 Unknown
2	w require been si should	Completed								24a. Was		24b. Were au	topsy findings available
T D	sician: The law certificate has b irector, page 2 s	duo								auto perfe 1 \( \text{Yes}	ormed?	death?	ompletion of cause of
VII	an: T tificat tor, p	BeC	25. Was case referred to medical					26. Plac	e of Death (0				
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatio	ent 2 ER	VOutpatier	nt 3 DOA	er: 4□N	lursing Home	5 🔀 Res	idence	6 □Other (Spec	ufy)
10 0			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		Bb. Time of Injury	Wor			d. Describe	how inju	ry occurred	
<u> </u>	endir eath. or: Al	catio	2 Accident investigatio					Yes 2		f I continu	/C44	d Musels and Div	and Points Mumber
UNISION	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director; Attention of the funeral birector; Attention of the funeral birector; Attention of the funeral birector of the funeral filled in by the f	ertification:	4 Homicide determined	286. Place of In	tc. (Specify)	e, tarm, str	reet, factory, office		281	City or To			ral Route Number,
_	spitel ours cours neral	O	29a. Certifier 1 Certifying Pl	nysicien: To the best	of my knowle	edge, deat	h occurred at the tir	ne, date a	and place, and	d due to the	cause(s)	and manner as	stated.
	ne Hoon 24 h	edical	(Check only 2 Medical Example)	miner: On the basis o and manner st	f examination ated.	n and/or in	vestigation, in my d	pinion, de	ath occurred	at the time,	date and	d place, and due	to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier		10.4	^ .~	29c. Licens	e number			29d. Da	te signed (Month	, Day, Year)
)	,			Jun	~ ~	117	D356	35			Janı	uary 29,	2004
	6		30. Name and address of person who							2005	0		
	)		Joseph Kaplan, MD 31. Date filed (Month, Day, Year)		ince F rar's Signatur		ip Drive;	Oln	ey, MD	2083			
***	Sta Registi		FEB 0 6 200			6	South	/					

			For State Ragistrar	State	of Marylar	•	artment o				iene	004	033	85
	wij.		Decedent's Name (First, Middle)	, Last)				-		2. Date of Dea		Yeer	3. Time of	Death
	Physici		Lucille		Essex		Howa	rd		Februa:	ry 4	2004	6:40	a M
•	/Medio Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Tow	n, or Location	n of Death		4c. Cou	nty of Death		
	CXdIIII	eı	Anne Arundel				Anna	apolis			Ann	e Arur	de1	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday	If Under 1 Ye	ear If Und	er 24 Hrs.	B. Date of Birth (Month, Day	1		lece (State o	r Foreign
т	Director		212-38-6904	1□M 2 <b>X</b> F	8	7 Yrs.	Months Da	ays Hours	Min.	Sept. 22	191	6 Mar	yland	
	4		Usual Residence of Decedent											
	how how		10a. State 10b. County		10c. Ci	ity, Town or L	ocation					1	0d. Inside Ci 1 ☐ Yes	
	Ma -1-8	cto	MD Anne	Arundel		Annap	olis							
	or 28	lre	10e. Street and Number				10f. Zip Cod	de		1		of What Cour	itry?	
	th wi	Funeral Director	1211 River Cı	escent D	rive			21401				SA		
	ems ems	ner	11. Marital Status	Armed F		J.S. 13.	Was Decedent If Yes, specify (	of Hispanic C Cuban, Mexic	Origin? (Spec an, Puerto R	cify Yes or No- lican, etc.)		lace - Americ llack, White,		
9	or it	F	1 X Never Married 2 ☐ Marr	If Yes. G	2 □ No live 1.0	,, ,	1 ☐ Yes 2 💢	No Specia	fy:		Spe	cify: W	hite	
8	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-1 show the Modical Enerther traist by notified at	d by	3 Widowed 4 Divorced	Year or	Dates: 19	44-64					40h Kind of	D	44	
7	nat Oce	Completed	15. Deceden (Specify only highe:	t's Education of grade completed	y	(Give	edent's Usual Oc e kind of work do DO NOT use re	one durina m	ost of workin	9	160. King of	Business/In	dustry	
12	vithir han	m	Elementary/Secondary (0-12)	College	(1-4or 5+)		jor	,,,,,,			U.S.	Δ rmsz		
2	e filed within al Hygiene. I other than '		17. Father's Name (First, Middle,	l ast)		114	JOI	18. Mot	ther's Name	(First, Middle,				
anc	ould be f Mental tarked of arked of	Be	Guy Briscoe H							Mariet				
Ĕ	2 should be and Mental is marked is umatic ev	ို	19a. Informant's Name/Relations			19h Mail	ing Address (Str						Code)	-
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, in a Madical Examiner mant be notified at		Sarah E. O'Da		`		Cedar 1					,,	,	
	1 and 1 Health tem 27		20a. Method of Disposition	y (Niece			osition (Name o					n - City or To	wn, Stete	
Š	Pages nent of int: If it iry or o		14⊒Burial 2 ☐ Cremation		n State				2 /7 /20	0.6	D = == f=	W-		3
Baltimore,	그 든 원 등	33	' 4 ☐ Donation 5 ☐ Other (S 21. Signator of Funeral Service		A:		Cemetery 2. Name and Ad		2/7/20	04	barst	ow, Ma	гутапс	1
Ba	Depariment of the popular in procession of the p		ZI. Signator of runoral convictor			1	Hardes	sty Fu	neral	Home, H	P.A.	MD 01	(01	
			23a. Part1. Enter the disease, or	condications that	caused the dea	th Do not en				Annar respiratory arr		MD 21	Approximate	Θ
8			shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.			.,,					Interval Bet Onset and (	
	Pnysician /Medical		disease or condition resulting in death)	a. >	epsi	5		- 0	^					
H	Examiner			Due to	o (or ma a conse	quence of):	vac	_ V	()	. 40	7-			
6		<u>~</u>	Sequentially list conditions,	b. Due to	o (or as a conse	quenci of):		. /		010				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	6	, stro	inte	ctinal	V X	روه	Line				
	be executed sician and burial-transit	Ха	that initiated events resulting in death) Last	c. Due to	o (or as a conse	quence of):	/E E	1			5			
760,	ate be executed nysician and he burial-transit	cal		d										
687	ficate phy s the													
Вох	leath certificat attending phy i for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn						23d.	Date of delive	эгу	
m	death a atte	cla	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pre	birth 2 Fet gnant at time of		□Ectopic pregn □ Other (specif)					Month	Day 1	Year
o.	that the d ed by the detached	Jys	9 Unknown	9□ Unk	nown									
٩	The law requires that the death certifical to has been signed by the attending phyage 2 should be detached for use as the	by PI	Part II. Other significant condition	ons contributing to	death but not re	sulting in the	underlying cause	e given in Pai	rt I.	23e. Did to	bacco use co	ontribute to the	ne cause of d	eath?
rds	quires n signe									1 🗆 Y	es 2 No	3 Prob	ably 4 □L	Jnknown
000	w requir	lete								24a. Was a		b. Were auto	psy findings	available
æ	The larate has	ompleted								autops perfor		death?	mpletion of c 2□ No	1038 ()
Vital Records,		ပိ	25. Was case referred to medica	1				26. Pla	ice of Death	(Check only or		10,103	20110	
>	Physician: this certific ral director,	OB	examiner?	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	Other		e 5 Resid		Other (Specif	y)	
of	g Phy ter this neral c	n: T	27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time	of 28c.	Injury at Work?		8d. Describe h				
ion	5 5 2	atlo	1 ☐ Natural 5 ☐ Pendir 2 ☐ Accident investi	ig .	min, Day real)	injury		1 Yes 2	□No					
Division	i or Attandi after death. Director: A	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	100d 286. Pla	ce of Injury - At I	home, farm, s	treet, factory, of	fice	2	8f. Location (S City or Town		mber or Rura	l Route Num	ber,
Ö	s after	Cert	4 Differences	-	aling, oto. (Opoo									
	To the Hospital or within 24 hours after To the Funeral Director completely filled in b		29a. Certifier 1 Certifyin	ng Physician: To t Examiner: On the	he best of my kn	nowledge, dea	th occurred at th	ne time, date	and place, a	nd due to the c	ause(s) and	manner as s	tated.	()
	tha H nin 24 the Fi	Medical	one)		nner stated.									
	To the To the Complex	Σ	29b. Signature and title of certifie	1 / (	1			cense numbe		2	.9d. Date sig	ned (Month,	Day, Year)	
1	.)		I Much	101	Sin	1	11.	530	41		2/	4/2	00 1	
	b		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type	Drint)			. 4		41 = 4		
			Michol Stau	Zime		Med	cot le	wy -	Tunc	PM	12	401		
	Sta Regist		31. Date filed (Month, Day, Year, FEB 0 6 2004	Signal 32.	Registrar's Sign	gyure A	Docks	-(						

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Physic	cian
/Med	ical
Exam	iner

1. Decedent's Name (First, Middle, Last)

**Funeral** Director

with the Marylend Hygiene. other than "natural", or items 23s or 28s-f show ent, the Medical Examiner must be notitied at filed within 72 hours efter death

10c. City, Town or Location 10a, State 10b. County Director Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 8141 Salt Lake Drive 21133 Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Cable Installer 17. Fether's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked ofth any injury or other traumatic event DRGs. Herman C. Harris 19a, Informant's Neme/Relationship (Type, Print) Elizabeth Harris (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 21. Signature of Funeral Service Licenses 8 e, or on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List out one cause on each line. 23a. Pert1. Enter the dis-Physiclan Immediate Cause (Final disease or condition resulting in deeth) /Medical METASTATIC COLON CANCER Examiner Due to (or es e consequence of) Examiner for use es the burial-transit or Attending Physician: The law raquires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medicai Due to (or as e consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. à δ within 24 hours after death.

To the Funeral Director: After this cartificate hes been signs completaly filled in by the funerel director, pega 2 should be Completed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 27. Magner of Deeth 5 Pending investigation Injun 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 \ Homicide Hospital 29a. Certifier (Check only one) ŧ 29c. License number 29b. Signature and title of certifier 2 MD D0031411 3

JANUARY 30, HARRIS RONALD 2004 5:20 AM 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) 8141 Salt Lake Drive Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 8, 194 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days Hours Months 10XM 2□ F Yrs. 1949 Maryland 54 219-52-2962 Usuel Residence of Decedent 10d. Inside City Limits 1 ☐ Yes 2√2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black. 16b Kind of Business/Industry Communications 18. Mother's Name (First, Middle, Maiden Sumame) Betty A. Thompson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 8141 Salt Lake Drive Randallstown, MD 21133 20c. Location - City or Town, State 1-4-04 Arbutus, Maryland 22. Name and Address of Fecility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave Catonsville, MD 21228 Approximate Interval Between Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yas 2 10 Other: 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Dav. Yeer) FEBRUARY 2, 2004 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) VA MEDICAL CENTER, 50 IRVING STREET NW, WASHINGTON, DC 20422 ROBERT WADLEIGH, M.D.,

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 6 2004

32. Registrar's Signeture

ILBERT J	JAMES	5	Please Type or Print in Black Indelible Ink. Ensure All	Copies Are	Legible.	
			State of Maryland / Department of Health and Me	ental Hygien	e) nnl	03387
		_	- State AMEND ITEM #10d PER FH G828 2/06/0 Centificate of Death	Reg. N	0.	0000:
	nysicia: Medica	n	1.11 0-0- 01050- 10000		ay Year 01, 2004	3. Time of Death
E)	xamine	r	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1190 West Northern Parkway  Baltimore	4	c. County of Death	MORE
	neral ector		1	8. Date of Birth Month Day, Year	9. Birth	place (State or Foreign
			Usual Residence of Decedent	W1,13)	ITAL DE	TUTTUKU
e Marylar	iffied at	ctor	MD BALTIMORE BALTIMORE			10d. Inside City Limits
with th	pend	Funeral Director	10e. Street and Number 10f. Zip Code 100. Street and Number 10f. Zip Code 210. 10f. Zip Code	10g. C	itizen of What Cou	ntry?
Jeath ns 23	TOWNS .	eral	1190 WEST NORTHERN PRWY 31210  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - Ameri	can Indian,
1215-0036 within 72 hours after death with the Maryland ene.	3	2	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R 1 Yes, Specify Cuban, Mexican, Puerto R 1 Yes 2 No Specify:	lican, etc.)	Black, White, Specify: 3	
72 hours	dical	ered	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of working life. DO NOT use retired)	16b. f	Kind of Business/In	dustry
nd 2121 e filed within al Hygiene.	t tra Ma	Completed	TWELVE FOUR SOCIAL SECURI	TY		NMENT
Vial Vial Menta Arked	other traumatic event, the Madical	10 Be	WILBERT JAMES SR. CARRI	(First, Middle, Maide E DOR	SEY	
e, Mar 1 and 2 sho Health and	her traum		19a. Informant's Name/Relationship (Type, Print) PEGGY WASHINGTON (SISTER) 19b. Mailing Address (Street and Number or Rural PEGGY WASHINGTON (SISTER) 19b. Mailing Address (Street and Number or Rural	TS AV BA	LTOMD	21215
imore, Pages 1 a ment of Hea	. p		20a. Method of Disposition  1  Burial 2 Officemation 3 Removal from State  4  Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  CREEN MOUNT  20c. Method of Disposition (Name of cemetery, crematory or other place)	104 B	ALTIMO	RE <sub>2</sub> MD
Baltim permit. Par Departmen	any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAI	JOHN C.	GREENE TONAL	FUNERAL PILS
174	- A.		23a. Part1. Other the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,		Approximate Interval Between
Physic /Med	dical -		Immediate Cause (Final disease or condition resulting in death)  Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):	ase		Onset and Death
Exam			Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
cuted	ial-transit	amme	cause. Citier Underlying Cause (Disease or injury that initiated events			
60, be execut	2 -		resulting in death) Last Due to (or as a consequence of):			
X 687(certificate I			d.		1-3	
	detached for use as the t	Friysicialiymedic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delive Month	ery Day Year
	be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
Cords, For requires that been signed	should b		CLINICAL MISTORY OF LVNG CANCER	1 ☐ Yes 2	Prob	ably 4 Unknown
as b	0 0	oll be	· ·	24a. Was an autopsy performed?	prior to con death?	psy findings available impletion of cause of
Vital F sician: Th	Be C	D	25. Was case referred to medical examiner? 26. Place of Death (		, , , , ,	
Division of Vital Records, after death.  I or Attending Physician: The law requires t after death.  Director: After this certificate has been signe	uneral dire	-	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28 Injury 28b. Time of Injury 28c. Injury work?	e 5 Residence 3d. Describe how inju	Other (Specificary occurred	SCENE
Jivisic or Attenc ifter death	ed in by the tunera	I	2 Accident investigation 3 Suicide 6 Could not be determined	3f. Location (Street a) City or Town, State	nd Number or Rura e)	l Route Number,
DIVISION Of To the Hospital or Attending Physwithin 24 hours after death To the Funeral Director: After this	completely filled in by the tuneral director, page Madical Cartification: To Be Com		29a. Certifier  (Check only one)    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an apid manner stated.	id due to the cause(s d at the time, date an	s) and manner as st d place, and due to	ated. the cause(s)
To the within	comple		29b. Signature and title of conflict.  29c. License number	29d. Da	ate signed (Month,	Day, Year)
6	Acrysta		30. Name and address of person with completed cause of death (Item 23a) (Type, Print)	Febr	ruary 02,	2004
	10		Margarita Konell M.D. 111 Penn Street, Baltime	ore, Mary	Land 2120	1

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

FER 0 6 2004

19 Sparks

32. Registrar's Signature

D 0 K

Baltimore, Maryland 21215-0036

**Physician** /Medical

**Examiner** 

physicien and s the burial-transit

attending ph for use as t

certificate has been signed by the rector, page 2 should be detached

Division of Vital Records, P.O. Box 68760

To the Hospitel or Attending Physician: within 24 hours after used...

To the Funeral Director: After this certification in the funeral director. Examine

Physician/Medical

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Completed

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Certification:

Medical

	For State Registrar					rtificat				lental Hyg	leg. No.		
Physician /Medical	1. Decedent's Nam	7IN	L. JONE							2. Date of Dea Month Februar	y 3 200		3. Time of Death $1305 \ p^{M}$
Examiner	4a. Fecility Name ( Sinai Ho		n, give street and nu	imber)			Town, or ltim	Location of	of Death		4c. Count	y of Death N	
Funeral Director	5. Social Security N 218-05-7		6. Sex 1 <b>X</b> M 2 □ F	7. Age (In y	rs. last birthday	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day SEPT. 3	(Year)	Cou	place (State or Foreigr ntry) MD
siyland show	Usual Residence o 10a. State	Decedent 10b. County		10c.	City, Town or L								10d. Inside City Limits
or 28a-f siles notified	MD 10e. Street and Nu	mber	NA			BALTI 10f. Zip					10g. Citizen of Whal Country?		
urs after death v	11. Marital Status  1 Never Marital 3 □ Widowed	ried 2∐ Mar	12. Was Dec Armed For ned 1 Tyes If Yes, Gi	orces? 2∐XNo ive	If Yes, specify Cuban, Mexican, Puerto Ric					ecrly Yes or No- Rican, etc.)	ty Yes or No- ican, etc.)  14. Race - American India Black, White, etc. Specify: AFRICAN AMERICAN		
ed within 72 hours ygiene her than "naturat", t, tre Medical Exe Completed by	(Spec	cify only highe	t's Education st grade completed)	1-4or 5+)	(Giv	edent's Usu e kind of wo DO NOT u	rk done d	during mos	t of worki	of working 16b. Kind of Bus			dustry
giene pr tha	111		0	1-401 57)		STU	DENT					CHOOL	
z should be riled within and Mental Hygiene. Is marked other than eumatic avent, Its M.  To Be Comp	17. Father's Name KELV			SR.					er's Name ENDOL	e (First, Middle, YN JAC	Maiden Sumai KSON	me)	
	19a. Informant's N			(FATHE		ing Address		and Numbe		al Route Numbe		. State, Zip. 2122	
permit. Pages 1 and 2 Department of Health a Important: If Item 27 in any injury or other tre once.	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location								20c. Location	,			

638 N. GILMOR STREET BALTIMORE, MD

23ar art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line.

Approximate Interval Betw

MultiPle Immediate Cause (Final disease or condition resulting in death) sushot wounds

Due to (or as a consequence of

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery

Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3**]**DOA

P 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 5 Pending

104 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3700 Block Beehler Ave, Bathingre GT

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

investigation 6 Could not be determined

> 29c. License number OCME

29d. Date signed (Month, Day, Year) February 4 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

27BILLAH

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)

25. Was case referred to medical

1 XYes 2 No

27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 Homicide

(Check only

FEB 0 6 2004

32. Registrar's Signature

			For State Registrar	State of N	-	epartmen Certificat			and Mental H	ygien Reg. Ne	2000	03389
			1. Decedent's Name (First, Middle, Las	t)		· · · · · ·			2. Date of I		ay Year	3. Time of Death
	Physici /Medio		Herman Jo	nnson					JAnuar	4 3	0 2004	21.38 PM
	Examin		4a. Facility Name (If not institution, give					Location o		40	c. County of Deat	
			Washington Cou				lager	stown			Washin	<del></del>
	Funeral		5. Social Security Number 6. S 219-78-6671	9X ▼ M 2□ F	Age (In yrs. last birth 40 Yr	Months	Days	Hours	Min. 8. Date of E (Month, I Nov 15	Day, Year 1 Q	63	hplace (State or Foreign buntry) unk
	Director		Usual Residence of Decedent		40				MOV 13	, 17	03	
	yland		10a. State 10b. County		10c. City, Town							10d. Inside City Limits
	Mar.	tor	MD Washing	ton	Hage	rstown						1 ☐ Yes 2X No
	or 28	)re	10e. Street and Number			10f. Zip	Code			10g. C	itizen of What Co	untry?
	23a	al	18600 Roxbury Ro	oad				21746			USA	
	d within 72 hours after death with the Maryland jene. Ir than "natural", or tlams 23a or 28a-1 show the Madical Examiner, untibe confilled at	Funeral Director	11. Marital Status unk	12. Was Deceder	s? unk	13. Was Dece If Yes, spe	dent of H cify Cuba	ispanic Ori in, Mexican	gin? (Specify Yes or f , Puerto Rican, etc.)	10-	14. Race - Ame Black, White	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2[ If Yes, Give Year or Date:		1 ☐ Yes	2 <b>X</b> No	Specify:			Specify:	black
9	tural	edi	15. Decedent's Ed	lucation	16a. D	ecedent's Usu	al Occup	ation	un'	16b. l	Kind of Business/	Industry unk
715	n "n	plet	(Specify only highest gra	de completed) College (1-4d		Give kind of wo ife. DO NOT u	ork done d se retired	during mosi i)	t of working			dille
212	d within giene. er then	Completed		nk	,, 34,							
Du	al Hygi I other vent,	Be	17. Father's Name (First, Middle, Last)				unk	18. Mothe	r's Name (First, Midd	le, Maide	n Sumame)	unk
yla	should be ind Mental is marked o	2										
Maryland 21215-0036	and and is r	- 4	19a. Informant's Name/Relationship ( Washington Count						r or Aural Aoute Num ceet Hager:			
	s 1 and if Health Itam 27 other tr		20a. Method of Disposition	y Hospite	20b. Place of D			III SCI	Date	-	Location - City or	
Baltimore,	Pages nent of H int: If the	١.,	1 Burial 2 Cremation 3		te cemetery,	crematory or o	other plac	(9)				
Ħ			'4 □ Donation 5 ☒ Other (Specifical Series Licer			22 Name a	nd Addres	ss of Facilit	v	-		
Ba	permit. Departr Importa		21. Signature of Euneral Service Licer	Wade, Di	vector				oard 655 W	. Ba	ltimore	Street
			23a. Pal 1. Enter the disease, or com	plications that caus	sed the death. Do no	Baltim t enter the mod	de of dyin	ig, such as	cardiac or respiratory	arrest,		Approximate Interval Between
	Pnysician		shook, or heart failure. List only Immediate Cause (Final		eat, c	En	Cep	hal	opally			Onset and Death
	/Medical		disease or condition resulting in death)	· ·	as a consequence of	):	,		( 4.			
	Examiner				patitis	C	-	10	fection			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or	as a consequence of				s inf	1. +	. A h	
	cate be executed obysician and the burial-transit	Examine	that initiated events		nan		no v	, vn	3 1 1.4	5 . (		
,00	e exe ian a urial-		resulting in death) Last	Due to (or	as a consequence of	):						
8760,	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	dical		d					· · · · · · · · · · · · · · · · · · ·			
9 x	eath certific attending pi	Physician/Med	IF FEMALE:	23c. If yes, outcor	ne of pregnancy						23d. Date of del	ivery
Box	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 ☐Ectopic p 5 ☐ Other (s		′			Month Month	Day Year
o	at the de by the	yslo	1 🖵 Yes 2 🗔 No 9 🗀 Unknown	9□ Unknowr								
۳.	that ned by deta		Part II. Other significant conditions of	ontributing to deat	n but not resulting in t	he underlying	cause giv	en in Part I	23e. Die	l tobacco	use contribute to	the cause of death?
Vital Records,	The law requires to has been significations	d by							10	Yes 2	2 1 No 3 □ Pr	obably 4 Unknown
Ö	w requir	lete							24a. W		24b. Were au	utopsy findings available
Re	The lavate has	Completed				,			pe 1 ☐ Yes	opsy formed? 2 N	death?	completion of cause of
tal		a	25. Was case referred to medical					26. Place	of Death (Check onl)			
	S : B	To B	examiner?	Hospital:	atient 2 ER/Outp	atient 3 D	Oth Oth	er: 4 □ Nu	rsing Home 5 🗆 Re	sidence	6 □Other (Spe	city)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of I (Month,	njury 28b. Tir Da <i>y Year)</i> Inj	ury	28c. Injun Wor	y at k?	28d. Describ	e how inji	ury occurred	
<u>0</u>	at at	atic	2 Accident investigation			М	1 🗆	Yes 2□				
Division	or Att	Certification:	3 Suicide 6 Could not b	288. Place of	Injury - At home, farr etc. (Specify)	n, street, factor	y, office			(Street a own, Sta		ural Route Number,
	urs af urs af ural D			1	- Touristan	A 103/100.00		1111 N	20 - 17 - 17 - 17 - 17 - 17 - 17 - 17 - 1	AMIES.		
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exar	niner: On the basis	ist of my knowledge, s of examination and/ stated	death occurred or investigation	at the tin n, in my o	ne, date an pinion, dea	d place, and due to the th occurred at the time	e, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner	olatou.	29	c. Licens	e number		29d. D	ate signed (Mont	h, Day, Year)
	F≱Fö		1 Fair w	hal		ĺ	Do	060	396	0	1/31/0	4
•			30. Name and address of person who	completed cause of	of death (Item 23a) (T	ype, Print)	6		.1 .		100	In wall
			FARIO MU	a site	0 1126	Opal	(°ou	r+	Hagerst	UWN	Mary	jano
	Sta	ate	31. Date filed (Month, Day, Year)	32 Reg	istrar's Signature	1 -0				-		
	Regist	rar	29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who  31. Date filed (Month, Day, Year)	04	yes At p	Special States						
_			1 60	and the same of th								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 400 A **Physician** 2 ARIENE MAI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bon Secours Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nonths Days Hours Min. Sept 22, 1 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 unk 5. Social Security Number **Funeral** 1 ☐ M 2 🖔 F 76 214-22-0244 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show r 28a-f show MD 1

Yes 2 □ No Baltimore Director 10e. Street and Number 1217 W. Fayette Street 10g. Citizen of What Country? 10f. Zip Code tems 23a or 2 21223 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Iter 1 ☐ Never Married 2 Married r than "natural", or if Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2000 W. Baltimore Street Baltimore, MD Bon Secours Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of I Important: If its eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State 21. Signatura of Funeral Service 22. Name and Address of Facility State Anatomy Board Daitimore, MD 21201 Licensee Wade 655 W. Baltimore Street 6 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner CUMONIG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 2No 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) pe 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) an 25 house MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28C Oronce 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 0 6 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year CAROL JANE JONES EBRUARY 2004 1:15 AM /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/22/1936 **Funeral**  Birthplece (State or Foreign Country) 1 ☐ M 2 🕱 F Days Director 212-36-7793 MARYLAND Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at MD BALTIMORE TOWSON Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? naturel, or items 23s. 108 EDGERTON ROAD Funeral 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. LAW-PRIVATE PRACTICE Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Important: If Item 27 ie marked other the eny injury or other traumatic event, it al 12TH GRADE LEGAL LIBRARIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HOWARD SCHMALBACH ARLYNE CHENOWETH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DR. WILMER JONES HUSBAND 108 EDGERTON ROAD TOWSON, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₽ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MORELAND MEM. PARK 2/6/2004 HILLENDALE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee Hattu 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY FAILURE disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit PERFORATED COLON WITH PELVIC ABCESS Due to (or as a consequence of): Box 68760. physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death P.O. 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, p page 2 should be CLOSTRIDIUM DIFFICILE COLITIS 1 Yes 2 X No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL ARRYTHMIAS autopsy performed 1 Yes 1 Yes 2 No 2 X No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After this of 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation To the Function after death,
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certified W 29c. License number 29d. Date signed (Month, Dey, Year) withreceur D 31826 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD INTHICUM M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 6 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U

		1 _ State	yland / D	epartment of F Certificate of	lealth and i	-	giene U	
		Registrar		Certificate of	Dealli	2. Date of D	Reg. No.	3. Time of Death
Physici /Medic		1. Decedent's Name (First, Middle, Last) Anita Lillian Johnson				Month I-el	2 2 2C	Year 810AM
Examir	ier	4a. Fecility Name (If not institution, give street and number)	xelAir	- BCIA	or Location of Death		4c. County of	Pord
Funeral Director			'In yrs. last birth Y	hday) If Under 1 Year Months Days	Hours Min.	8. Date of Bi (Month, D June	rth ay, Year) 28, 1915	9. Birthplace (State or Foreign Country) Maryland
		Usual Residence of Decedent						
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Department of Heatil and Mental Hygiene. Separtment of Heatile 27 is marked other than "natural", or Itams 23a or 28a-f ahow any injury or other traumatic event, the Medical Exam per must be notified at ange.	tor	Md. Carroll	Oc. City, Town	Eldersburg	5			10d. Inside City Limits 1 ☐ Yes 2 No
n the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Country?
th with	a D	2309 Harvest Farm Road		21	.784		Unite	ed States
deat	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cuba	Hispanic Origin? (S	pecify Yes or N	o- 14. Race	- American Indian, (, White, etc.
036 urs after all; or Its	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:	.,,	Specify:	
Maryland 21215-0036 d2 should be filed within 72 hours aff the and Martal Hygiersh are trained other than "natural; or traumatic event, the Maulical Examinations of the contractions of the contractions of the maulical Examinations of the maulical Examinations of the contractions of the	Completed	15. Decedent's Education (Specify only highest grade completed)	-	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	petion during most of wor d)	king	16b. Kind of Bus	siness/Industry
vith iene.	E O	Elementary/Secondary (0-12) College (1-4or 5+) 12 years		homemaker			own	home
ent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle	, Maiden Sumame	e)
land be rice.	To B	William Brown			Grace	Vogt		
ary		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street	and Number or Ru	ral Route Numb	er, City or Town, S	State, Zip Code)
mand 2		Charles Johnson/son		25 Beechban				
Baltimore, semit. Pages 1 at separament of Hea mportant: if item any injury or othe ang.		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)		Disposition (Name of y, crematory or other plac w Crematory		Date /04	Baltimo	City or Town, State
altii mit. i parim oortai / injui		21. Signature of Funeral Service Licensee	-	22. Name and Addre	ess of Facility	1 Uome	of Dol A	in The
Bal permi Depa Impo		1 /can	7		iek Funera MacPhail			
ec		23a. Pert1. Enter the disease, or complications that ceused th shock, or heart failure. List only one cause on each line.	e death. Do n	ot enter the mode of dyir	ng, such as cardiad	or respiratory	arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	10	Ronal =	Failur.	c .		Onset and Death
/Medical		resulting in death)  Due to (or as a continuous)	onsequence o	f):				Ten year
Examiner	L	Sequentially list conditions, b.		41.				
pe tis	Jine.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	:onsequence o	n).				
60, be executed ician and burial-transit	Examiner	that initiated events c. Due to (or as a c	consequence o	f):				
	aiE							
	edic	<b>3</b>						
Box death cer e attendir	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 [ 4 □ Pregnant at time of the pregnant at t	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	у		23d. Date Mon	of delivery th Day Year
ords, P.O requires that the een signed by the hould be detach	y Ph	Part II. Other significant conditions contributing to death but of	not resulting in	the underlying cause giv	ven in Part I.	23e. Did	tobacco use contri	bute to the cause of death?
rds, rds, and signer and be		Severe Anomic	i of	Chronic	c Illne	10	Yes 2 10	3 ☐ Probably 4 ☐ Unknown
Record he law require has been singe 2 should	Completed				- , ,	24a. Was		ere autopsy findings available
I Reco	E					auto perf	ormed? de	rior to completion of cause of eath?
F Vital Reysiden: The Iss certificate hadirector, page	Be C	25. Was case referred to medical			26. Place of Dea			3103 22110
of Vital Of Vital Physician: This certifical	ToB	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Out	patient 3 DOA Oth	ner: 4 ursing H	ome 5 Res	idence 6 Othe	r (Specify)
		27. Manner of Death 28a. Date of Injury 1 ■ Natural 5 □ Pending (Month, Day Y	(eer) 28b. Ti	ime of 28c. Injur	ry at rk?	28d. Describe	how injury occurre	d
/ision //ision Attending r death. sctor: Atte	attic	2 Accident investigation			Yes 2 □No			
DIVIS Blor Attu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc.		m, street, factory, office			(Street and Numbe wn, State)	r or Rural Route Number,
Divisit  Divisit  To the Hospital or Attention 24 hours after death To the Funeral Director:	edical (	29a. Certifier (Check only one) 1 Certifying Physician: To the best of roughly and manner states	xamination and	death occurred at the tir Vor investigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed	(Month, Dey, Year)
		> Thermil MA	1	no	D195	83	Febru	11V 2 2000
U		30. Name and address of person who completed cause of goal	th (Item 23a) (	Type, Print)	Land	trat	*	21021
1	1	MILLIAN MALAZATO	N M7	D 4	1 2 2	11001	. Mary	Land

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Edward KOLD SINSK Februar 2004 /Medical 4b. City, Town, or Location of Deeth 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Baltmore N/A UNIVERSITY Mayland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 25,1932 Birthplece (State or Foreign Country) 6 Sex **Funeral** Days Hours Min. 1**√2** M 2□ F 203-24-9793 71 PA Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Items 23a or 28a-f show the Medical Examiner must be notified at PA Lacka Dickson City 1√Xes 2 No by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 524 Morgan Street 18519 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. TYPE 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant if item 27 is marked other than "naturat", or Ite ury or other than the faction any or other traumatic event, the Medical East ring 1 Never Married Amarried 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Floor Person Record MFG. 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Kolosinsky Mary Lahousky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Kolosinsky / Wife 524 Morgan Street, Dickson City PA 18519 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Bay View Crematory Feb. 5, 2004 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave., Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oulmonar **Physician** /Medical Due to (or as a consequence of **Examiner** Securitally fish our divines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending physicier IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ate has been signe page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 X No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

To the Hospitel

with the Maryland

death

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

or Attending Physician:

State Registrar 31. Date filed (Month, Day, Year)

FFR 0

29b. Signature and title of certifier

32. Registrar's Signature 6 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** 2004 1:00P January 29, Josie Elise Keebler /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🛛 F Director 577-46-9232 74 3. Tennessee Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worle Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

ant: If item 27 ie marked other then "naturat", or itema 23e or 28a-f ehow ury or other treumatic event, it a Musical Extention and the mutilised at 1 X Yes 2 □ No Washington, DC DC Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20008 United States 2800 Quebec Street NW; Apt. 1047 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 ☐ Married I □ Yes 2 1 No II Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paralegal Legal 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Josie Elise Paxton Robert Samuel Keebler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 11612 SOurwood Lane; Reston, VA 20191-3012 Janet N. Keebler/Sister in Law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. Loudon Park Crematory 02/5/2004 Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Name and Address of Facility Funeral and Cremation Center Lines 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Ovarian Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to in reclate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 88 IF FEMALE 23c. Il yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) I □ Yes 2 No the 9 Unknown 9 Unknown signed by 1 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 certificate 1 ☐ Yes 2X No 2 No or Attending Physician: ector, 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 Accident Il Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, Jarm, street, Jactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after the Hospital within 24 hours a 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier January 30, 2004 D56439 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Sharon Turban, MD

FEB 0 6 2004

31. Date liled (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

9901 Medical Center Drive; Rockville, MD 20850

			State of Maryland / Department of Health an  1- State Registrar  Certificate of Death	-		03395
			1. Decedent's Name (First, Middle, Last)	2. Date of I	Death Day Yeer	3. Time of Death
	Physici /Medio		YUNN HETEN KESTER	JAN	29 2000	
	Examin		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of the control of t	Death	4c. County of De	
			UPPER CHEJAPEAKE MEDICAL CENTER BELAT.		HARFO	
	Funeral Director		220-07-7843	Min. Sept.	<sup>9. Bi</sup> 21, 1917 M	rthplace (State or Foreign ountry) aryland
	pur *		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	lanyli sho	5	I I I I I I I I I I I I I I I I I I I			1 □Yes 2 □ No
	28a-	ect	Md. Harford Joppa  10e. Street and Number 10f. Zip Code		10g. Citizen of What C	
	with Sa or	٥	301 Trimble Road, Apt. Al 21085		United Sta	
E	death with the Maryland ims 23a or 28a-f show f must be padified at	Funeral Director	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin	n? (Specify Yes or I	No- 14. Race - Am	
5 Cm	or Her	Ŧ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	Puerto Hican, etc.)		ite, etc.
30,0	al', c	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: W	hite
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	of working	16b. Kind of Busines	s/Industry
7 7	ithin Ben W	npje	Elementary/Secondary (0-12)   College (1-4or 5+)		florist	
2	led w lygier her ti	ဒ္	8 years floral designer  17. Father's Name (First, Middle, Last) 18. Mother's	Nome (Eiset Mide	dle, Maiden Sumame)	
land	uld be fi fental H rked ot tic ever	To Be		nna Deppe		
$I=J\mathcal{Q}q/c\psi$ //: /5- $G$ Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be inclined at once.	1 7	19a. Informant's Name/Relationship (Type, Print)  Rosanne Seabright/daughter  19b. Mailing Address (Street and Number of South Cherokee Place)	or Rural Route Num	nber, City or Town, State, r, Md. 21015	Zip Code)
e,	Heal Heal tem S		20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)	Date	20c. Location - City o	r Town, State
129 nore	ages ent of ht: If		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Highview Mem. Gdns. 2	/3/04	Fallston,	Md.
	artme ortan injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility			
B	Deg de de de de de de de de de de de de de		Schimunek Fune 610 W. MacPhai			
		-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	ardiac or respiratory	arrest,	Approximate Interval Between
	Physician	6 1	Immediate Cause (Final			Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):			1
	Examiner		Sequentially list conditions b.			
211	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, United Sequence of Juny that initiated events c.			
1.1	ate be executed hysician and he burial-transit	Examiner	Causes (Disease or kiljury that initiated events resulting in death) Last  Due to (or as a consequence of):			
760,	be exec ician an burial-tr		resulting in death) Last Due to (or as a consequence of):			
876	sate b	dlcai	<b>d</b> .			
P.O. Box 68	ding p	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			
Bo	attend for us	lan	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of de Month	Day Year
o	he de	yslo	1 Yes 2 Live 9 Unknown 9 Unknown			
		H.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Dio	d tobacco use contribute	to the cause of death?
Sp	uires sign ld be	d b	CONGEDINE HEART FAILURE	10	⊒Yes 2□No 3□F	robably 4 Ninknown
7 0	w req	lete	Chronic obstructive Outmoney DISETT	24a. W	as an 24b. Were a	utopsy findings available
$A_{RR} = Keller$ Division of Vital Records,	siclan: The law requires that the death certifical certificale has been signed by the attending phrector, page 2 should be detached for use as the	Completed by	CHLONG RENAL FRILLIE	pe	rformed?   death?	completion of cause of
fa	an: ] tifica tor. p	BeC	25. Was case referred to medical 26. Place of	f Death (Check only		2 2 2 3 10
2	ysicl is cer direc	<u>0</u>	examiner?  1 New Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursi	ing Home 5 ☐ Re	esidence 6 🗆 Other (Sp.	ecify)
0	ng Ph ter th neral	Ë	27. Manner of Death 1 Salatural 5 Pending (Month, Day Year) 28b. Time of Injury at Work?		e how injury occurred	
sion a	endir sath. or: Al	atk	2 Accident investigation M 1 Yes 2 No			
Ann Divisi	r Att ter de irecte irect	Certification; To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		n (Street and Number or F Fown, State)	Rural Route Number,
40	ital curs af			-		
	To the Hospital or Attending Physiclan: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	Medical	29a. Certifier  (Check only one)  1 ☐ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and processing the date and processing the	place, and due to the concurred at the time	ne cause(s) and manner a e, date and place, and du	s stated. e to the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certifie 29c. License number		29d. Date signed (Mor	th, Day, Year)
	1		Manufalle M. D 21800	ન	JAN 29	2004
-	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
_				NONIUN	1 MO 210	43
	Sta Regist		31. Date filed (Month, Day, Year) B 0 6 2004 Signature			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 0414 a. M Februar Ruth Estelle Keene 2004 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. are 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1 ☐ M 2 🖾 F 219-30-6092 Director 69 Aug 16,1934 Maryland Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examinar must be motified at 1 □ Yes 2 ☑ No Maryland Baltimore Baltimore the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1302 Dorchester Avenue 21207 U.S.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after of tent of Health and Mental Hygiene. Tent of Health and Mental Hygiene. Black. White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Joyce Ruth Lohmeyer ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) Henry Keene 1302 Dorchester Avenue Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 0 = 0 1 X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department Importent: II any injury or <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery | 2-9-2004 Baltimore, Maryland 21. Signatury of Furbral Service Licensee 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, MD 21228 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition **Qnset and Death** thero sclentic Pnysician Cardwiascular disease wurs resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Litia to (or as a consequence of) Examiner ed by the attending physician and detached for use as the buriat-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 □Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be & moncen 3 Probably 4 @Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy this certificate 1 Yes 2 No ector. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 2 ► ER/Outpatient 3 DOA 1 Inpatient inneral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the ! 29b. Signature and title of certifier 29c. License number Belleulet) completed cause of death (Item 23a) (Type, Print) Buttomore, Mary loud H. Schuggs du) 900 Catron Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1- For State of Maryland / Dep	partment of Health and Mental Hygiene 0 14 0 3 3 9 7 ertificate of Death
		2	Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici /Medic		Thomas J. Lamana	February 2, 2004 7:05 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
			6352 Frederick Road	Catonsville Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	y If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country)
и	Director		215-52-2453 1MM 2 F 55 Yrs.	Nov. 16, 1948 Maryland
	pu .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation 10d. Inside City Limits
	sho	5		ott City 1 □ Yes 2 \( \overline{\text{No}} \)
	28a-f	ect	10e. Street and Number	10f, Zip Code 10g, Citizen of What Country?
	a or	Dir		
	eath	era	8369 G Montgomery Run Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	21043 United States Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
10	r Iten	Funeral Director	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, White, etc.
93	urs a	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify: White
Ö	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Medical Examinst must be notified at	Completed		edent's Usual Occupation 16b. Kind of Business/Industry
21:	thin 7	nple	(Specify only highest grade completed) (Giv Elementary/Secondary (0·12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)
2	ed wi	Con		repreneur Auto repair
p	d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
<u>Y</u> a	ould Men Marke Marke	ို	John A. Lamana	Eleanor M. Kairis
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	l and lealth im 27 ther t			G Montgomery Run Road, Ellicott City, MD 21043
Baltimore,	ges it of the If ite		1 2 DOIGHIATION 3 DINGHIOVALITORII STATE	osition (Name of Date 20c. Location - City or Town, State amatory or other place)
Ė	t. Pa tmen tant: vjury			ark Cemetery Feb 6,2004 Baltimore, Maryland
Bal	Depa Depa Impo any ir			22. Name and Address of Facility Hubbard Funeral Home, Inc.
	40100			107 Wilkens Avenue, Baltimore, Maryland 21229  ther the mode of dying, such as cardiac or respiratory arrest.  Approximate
			23a. Parf.1. Sinter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on lach line.  Immediate Cause (Final	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	and hanging
34,	Examiner		Due to (Ar as a consequence of):	
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
	uted d ansit	Examine		
ó	exec an an rial-tr	Exa	resulting in death) Last  Due to (or as a consequence of):	
8760,	cate be executed physicien and the burial-transit	Physician/Medical	d	
9	ng ph	Med	IF FEMALE:	
Вох	th ce tendi	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	□Ectopic pregnancy
	that the death certificed by the attending podetached for use as	Sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify) Month Day Year
P.0	at the	Phy	9 DONAHOWH	
Ś	8 6 9	by	Part II. Other significant conditions contributing to death but not resulting in the	
Division of Vital Record	w requir been si should	Completed		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
ec	e law has b	npie		24a. Was an autopsy prior to completion of cause of
E	ttending Physician: The Jeath. tor: Alter this certificate ha the funeral director, page	Co		performed? death?  1 \( \text{Yes} \) Yes 2 \( \text{No} \)
Vita	ician sertifi ector	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check only one)
of	Phys this al dir	2	Tes 2 140 1 Inpatient 2 En/Outpatie	Z (CEX
L C	ting After funer	Certification:	1 □Natural 5 □ Pending (Month, Day Year) Injury	Work?
<u>isi</u>	death death stor: / the	ical		D5A Self-inflicted hanging  seet, factory, office Self-inflicted hanging  28f. Location (Street and Number or Rural Route Number,
<u>&gt;</u>	l or Atten after deatl Director: I in by the	ertif	4 Homicide  4 Homicide  4 Sucide  4 Sucide  4 Sucide  4 Sucide  4 Sucide  4 Sucide  4 Sucide  4 Sucide  4 Sucide  4 Sucide  4 Sucide  4 Sucide  4 Sucide  4 Sucide  4 Sucide  5 Sucide  6	
	Hospital 24 hours a Funeral stely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	6352 Frederick Rd, Catonsville th occurred at the time, date and place, and due to the cause(s) and manner as stated. MD 21228
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medicai		ovestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
			J. Custom Danavan, MD	8000 7632 Feb. 4, 2004
	P1		30. Name and address of person who completed cause of death (Item 23a) (Type	
_			TICROSSAN O'GONOVAN MD. 2112	DUNDALK AVE BALTO MD 21222
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 6 2004	L.2.
100	ricgisti	41	FED O CLOOL MENTINGS YES	

	1 - For State Registrar		Certificate of Death	Reg.	No.	
Physician /Medical	Frances G. Medicu	ıs	a Charles of Day	Feb. 4, 2	Day Year	3. Time of Death
Examiner Funeral Director	Somerford Place 5. Social Security Number 6. S 215-07-5835		4b. City, Town, or Location of Dea  Columbia  t birthday)   If Under 1 Year   If Under 24 Hrs  Months   Days   Hours   Min	s. 8. Date of Birth		ace (State or Foreigr try) 1land
Marytann 1-1 show Illustant	Usual Residence of Decedent 10a. State 10b. County Maryland Howard		own or Location arksville			0d. Inside City Limits 1 ☐ Yes 2√ No
which is a route steel beath with the maryanous than "natural", or items 23s or 28s-1 show in Michael Examiner must be rediffed at morpheted by Funeral Director			10f. Zip Code 21029		Citizen of What Count	
iene. rthan "natural", or items 23a or 28a-1 show the Medical Examinat fundat be recitified at ompleted by Funeral Director	31 Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e Specify:	
ygiene. 1, tre Medical E. Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12)	College (1-4or 5+)	Decedent's Usual Occupation     (Give kind of work done during most of wollife. DO NOT use retired)      The conconcur.	orking	Eleven Che	,
od other event, t Be Cc	17. Father's Name (First, Middle, Last)			ame (First, Middle, Meid Schueler	Floral Sho	Þ
item 27 Is marke other treumatic	19a. Informant's Name/Relationship (1 Suzann D. Medicus	/ Daughter	19b. Mailing Address (Street and Number or R 7391 Hopkins Place (	Clarksville	, Md. 2102	9
Department of H Important: If itse any injury or ott once.	20a. Method of Disposition  1 Surial 2 Cremation 3 Control Control  1 Control Control  21. Ignature Funeral Service Licen	(y) Lake		7/04 Sy	kesville,	Md.
Impo any i	23a. Pert1. Enfer the disease, or comp	plications that caused the death. D	4107 Wilkens Avenu		re, Maryla	nd 21229 Approximate
ysician Medical taminer	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence	the heat Fall			Interval Between Onset and Death
ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence.	e Deneten			YA
been signed by the attending physicis should be detached for use as the bur letted by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	ath 3 ☐ Ectopic pregnancy		23d. Date of deliver	y Day Year
en signed by rould be detac ted by Ph	Part II. Other significant conditions of	ontributing to death but not resulting	ig in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	a cause of death?
B 宏 .				24a. Was an	prior to com	sy findings available pletion of cause of
ficate has been sor, page 2 should				autopsy performed 1□ Yes 2 1 1		₹ No
ath. r: Atter this certificate has e funeral director, page 2 atton; To Be Comp	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	(Month, Day Year)	04	performed	No 1 ☐ Yes 2	Λ
rs atter death. rel Director: After this certificate has led in by the funeral director, page 2 Certification; To Be Comp	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At home, building, etc. (Specify)	/Outpatient 3 DOA  b. Time of Injury  M  1 Yes 2 No  n, farm, street, factory, office	performed'    Yes 2 1 1     Yes 2 1 1     Yes 2 1 1     Yes 2 1 1     Yes 2 1     Yes 2 1     Yes 2 1     Yes 2 1     Yes 2     Yes 3     Yes 3     Yes 3     Yes 3     Yes 4     Yes 4     Yes 4     Yes 4     Yes 4     Yes 4     Yes 4     Yes 4     Yes 5     Yes 4     Yes 5     Yes 6     Yes 6     Yes 6     Yes 6     Yes 6     Yes 7	No 1 □ Yes 2  6 □ Other (Specify)  njury occurred  and Number or Rural (ate)	Route Number,
within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification; To Be Comp	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Ph. 2 Medical Exam	28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At home, building, etc. (Specify)	/Outpatient 3 DOA  b. Time of Injury  M 1 Yes 2 No  darm, street, factory, office  Dige, death occurred at the time, date and place and/or investigation, in my opinion, death occurred at the time.	performed 1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2	No 1 Yes 2  6 Other (Specify)  njury occurred  and Number or Rural in are)	Route Number, ted. the cause(s)
n 24 hours after death.  Ne Funerel Director: After this certifuterly filled in by the funeral director plately filled in Cartification; To Beedical Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who of the determined	28a. Date of Injury 28b. (Month, Day Year)  28e. Place of Injury - At home, building, etc. (Specify)  any sicien: To the best of my knowing and manner stated.	/Outpatient 3 DOA  b. Time of Injury  M  28c. Injury at Work?  M  1 Yes 2 No  darm, street, factory, office  dge, death occurred at the time, date and place and/or investigation, in my opinion, death occurred at the time, D 2 6 2	performed 1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   Yes	No 1 Yes 2  6 6 Other (Specify)  njury occurred  and Number or Rural ate)  6(s) and manner as stall and place, and due to to to the control of the control o	Route Number, ted. the cause(s) ley, Year)

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer Month David **Physician** Minter 7:45 Am 2004 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner 3511 Leslie Avenue Temple Hills, MD Prince Georges If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**⊠**M 2□ F 243-09-9257 91 March 27,1912 Director SC Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r than "natural", or Items 23a or 28a-f show tre Medical Examiner must be notified at Temple Hills 12€ es 2 No Prince Georges Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20748 3511 Leslie Avenue death \ Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No **Black** Specify Specify þ 3 1 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Manufacturing Laborer 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be Jessy Gilmore Jessie Minter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alesia Cox / Daughter 3511 Leslie Avenue, Temple Hills MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Trinity Cemetery January 30, 2004 Detroit, MI \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 21. Signature or Funeral Service Licensee Victor P. Doda, Jr. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Altzheimer's Disease resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Renal Failure Due to (or as a consequence of): Examiner The law requires thet the death certificate be executed Anemia, Non Specific and Due to (or as a consequence of): attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUX known peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2XX No 24a. Was an has page 2 perform certificate 2**X**00 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Daughters House Other: 1 Yes 2 XNo 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 2 ER/Outpatient 3□ DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral 27 Manner of Death Certification: or Attending Injury 5 ☐ Pending 1 ☐Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No death. investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours after To the Funeral Dire the Hospitel XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28079 Jan. 23, 2004 suden ho 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellicott City MD Francine Higgs-shipman, MD 5082 Dorsey Hall Drive, Suite 103 31. Date filed (Month, Day, Year) 2. Registrar's Signature State FEB 0 6 2004 2341 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		·	For State Registrar	State of Maryland /	Department of Health and I Certificate of Death	Mental Hygier	C 0 0 0 0	3400
	Dharaisia		1. Decedent's Name (First, Middle, Last)	1		2. Date of Death Month	Day Year 3. T	Time of Death
	Physicia /Medic		String	marshall		Thebutary	2 2004 /	: GFPM
	Examin	er	4a. Facility Name (If not institution, give s	street and number)	4b. City, Town, or Location of Deetl		4c. County of Deeth	1000
			5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24 Hrs.		9. Birthplace (	State or Foreign
	Funeral Director			IM 200 62	Yrs. Months Days Hours Min.	Month, Day, Ye.	941 Mari	State or Foreign
	pu ,		Usuel Residence of Decedent  10a, State 10b, County	100 City To	un au l'acetie		104 Inc	side City Limits
	shov	70	10a. State 10b. County	Toc. City, 100	wn or Location			Yes 2 No
	28a-f	Director	10e. Street and Number	DU	10f. Zip Code	10g.	Citizen of What Country?	
	3a or		2612 Oak	Ave	21207		11 SA	
	deatl	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Ind Black, White, etc.	dian,
36	hours after death with the Maryland tural', or Items 23s or 28s-f show at Examinat must be motified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	, ,	Specify: D	L
21215-0036	within 72 hours after death with the Marylan jene. then "natural", or Items 23s or 28s-f show then "wellcal Exantine must be notified at	ed b	15. Decedent's Edu		a. Decedent's Usual Occupation	16b.	Kind of Business/Industry	_
215	in na	plet	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of work done during most of world, DO NOT use retired)	king	0 11	
212	filed within Hygiene. Ither than out, the Met	Completed	2	0	Homemaker		Dwn Ho	me
pu	ed is b	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Maid	len Sumame)	
Z	should be and Mental a marked o	2	19a, Informant's Name/Relationship (Ty	na Print)	b. Mailing Address (Street and Number or Ru	ral Boute Number Cit	y or Town, State, Zip Code,	1
Maryland	d 2 s th ar th ar trau		Ms Shirley	100, Print) 3 mm kter) 19	3613 Dak Ave	Palto.	Md. 212	017
	s 1 and of Health item 27 other ti		20a. Method of Disposition	/ / comot	of Disposition (Name of ery, crematory or other place)	Date 20c.	Location - City or Town, St	tate
E	8 = 5		1 Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	Mem Park 2/9/	2004 F	salto. Ma	1
Baltimore,	permit. Pag Department Important: eny injury c		21. Signature of Funeral Service License	L. Russ	22. Name and Address of Facility  JOSEPH L. RUSS	Funeral	Home 21	216
			23a. Parti. Enter the disease, or complishood, or heart failure. List only or	cations that saused the death. Do	not enter the mode of dying, such as cardiac	or respiratory arrest,	Appro	oximate val Between
	Physician		Immediate Cause (Final disease or condition	Dhala hack	0 /		Onse	et and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):			
2	- Adminion	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of):			
	ned Insit	Examiner	Cause (Disease or injury					
ó	te be executed ysician and te burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence	• of):			
68760	⊕ × e	lcal		J				
% 68	entifica ling pl e as t	Med	IF FEMALE:	0-16				
Box	death certifica e attending ph ed for use as th	Physiclan/Med	in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel deat 4 ☐ Pregnant at time of death	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery  Month Day	Year
P.O.	0 0 0	nysic	1 Yes 2 No 9 Onknown	9 Unknown	3 Other (specify)			
	The law requires that the ate has been signed by th page 2 should be detache	by Pt	Part II. Other significant conditions con	stributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cau	se of death?
Records,	v require been sig should b	edb	End stage	of Renal	Disacep	1 ☐ Yes	2 No 3 Probably	4 Unknown
ecc	e law requ has been je 2 shoul	Completed	/			24a. Was an autopsy	24b. Were autopsy fin prior to completic	ndings available
E		Соп				perfórméd 1 ☐ Yes 2 ☑	death?	
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	04	th (Check only one)		
ot	Phys this ral di	. To	1 Yes 2 No	1 Inpatient 2 EH/C	otpatient 30 DOA 40 Indishig i	ome 5 Residence		
	or Attending I after death. Director: After in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Time of Injury at Work?  M 28c. Injury at Work?  1 \( \subseteq Yes \) 2 \( \subseteq No \)		,,	
Division	Atten	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Rout	e Number,
Ö	itel or irs afte rel Div	Cerl		January,				
4	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: Att completely filled in by the fun	Medical	29a. Certifier (Check only one)  1 Certifying Physical Examination	sician: To the best of my knowledgener: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place ind/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. and place, and due to the ca	ause(s)
	To the within To the comp	M	29b. Signature and title of certifier		29c. License number	29d. l	Date signed (Month, Day, Y	(ear)
			Alica	1-10/	143974	-in	1 wor 2, 70	400
	2		30. Name and address of person who co	impleted cause of death (Item 23a	(Type, Print)	Δ .	tour, by	
	- 64		31. Date filed (Month, Day, Year)	32. Registrar's Signature	of Hopital	100mballs	tour, h	2 4 4 p.
	Sta Registr		0.0.000	Leave B	Sporter			/
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DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Matczak February 4 2004 8:00 а /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🗆 M 046-36-8834 80 Aug. 1923 Russia Director Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or Items 23a or 28e-f show any hjury or other traumatic avant, the Medical Examinating the notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Director MD Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3170 Catrina Lane 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Jacob Mielnik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Halyna Pagano (Daughter) 3170 Catrina Lane, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State Metro Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) Feb. 6, 2004 Baltimore, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final astro intesti **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner schem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Duja to (ur as a consequence of): by Physician/Medical Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-tran and that initiated events resulting in death) Last Box 68760, the attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Year Day be detached for 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1E Yes 2 □ No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To 2 ER/Outpatient SIU 28b. Time of 27. Manner death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 1 Matural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by within 24 hours after To the Funerel Direct 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated. 29d. Date signed (Month; Day, Year) and title of certifier 29c. License number 29b. Signatule who completed cause of death (Item 23a) (Type, Print) 30 Name and address of pers Stanzione Michal 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FFR 0 6 2004

		-	For State Registrar	Ficase	State of		d / Dep		of He	alth and N	•		200	0340	()
	telos e	-	Decedent's Name	e (First, Middle, Las	t)						2. Date of De	eath		3. Time of Death	n
_	Physicia		Mary Mir	raslav Nei	lson						Month O 2	Da	+ 2004	11111000	М
	/Medica Examine		4a. Facility Name (II	f not institution, give	street and numi	ber)		4b. City, To	own, or L	ocation of Death		40	. County of De		
			Alice Ma	anor Nurs	ing Home					altimore	9				
<b>0</b> (*)	Funeral Director		5. Social Security N 201-09-1	1	9x 7 □ M 2□ F	. Age (In yrs.	last birthday, 85 Yrs.	If Under 1 Months	Year Days	Hours Min.	8. Date of Bi (Month, Di Jun 19	ay, Year,	9. B 918 PA	rthplace (State or Fore Country)	ign
	p ,		Usual Residence of	Decedent 10b. County		100 Cit	y, Town or L	anting						10d. Inside City Lim	site
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Heatih and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, the Medical Examinar must be notified at	5	10a. State MD	N/A			ltimor							1 Yes 2 1	
	288-1	rect	10e. Street and Nur			Ва	1011101	10f. Zip C	Code			10g. Ci	tizen of What (	Country?	
E	3a or	<u> </u>		krose Ave	enue			2121	11			Un	ited St	ates	
11pm	me 2	era	11. Marital Status		12. Was Deced	lent Ever in U.	.S. 13.	Was Decede	nt of Hisp	anic Origin? (Si Mexican, Puerto	pecify Yes or No	0-	14. Race - An		
	after or Ite	Ī	1 Never Marri	ied 2□ Married	1 Tes 2	2 No		1 ☐ Yes 2		Specify:	o nican, etc.)		Black, Wh Specify:	ITO, 01C.	
9 8	72 hours after natural', or Ite	àb	3 Widowed	4 Divorced	Year or Dat	les:		10105 2		Specify.			Wh	ite	
ે દુ	72 h	etec	(Spec	15. Decedent's Ed	lucation de completed)		(Give	dent's Usual kind of work	done du	on ring most of wor	king		(ind of Busines		
2/4/04 @ <b>21215-0036</b>	e filed within al Hygiene. I other than "	Completed by Funeral Director	Elementary/Seco	ondary (0-12)	College (1-	4or 5+)	Wait	DO NOT use	retirea)			HOS	spitali	tу	
	Hygie ther	ပို	17. Father's Name	(First, Middle, Last)			Haze	1000	1	8. Mother's Nan	ne (First, Middle	, Maidei	n Sumame)		
an a	d be antal	To Be		Omelon						Marie I	Riznuk				
Nelson - Maryland	shoul nd Ma marl	۲	19a. Informant's Na	ame/Relationship (	Type, Print)		19b. Mail	ing Address (	Street an	d Number or Ru	ral Route Numb	er, City	or Town, State	Zip Code)	
<u> </u>	alth a 27 lg		Sr. Patr	cicia Rog	uci/Frie	end	42 S	. Popp	leto	n Stree	t, Balt	imor	e, MD 2	1201	
M. ore,	of Hei		20a. Method of Disp	position	D. may all tram C		Place of Disp cemetery, cre	osition (Name matory or oth	e of ner place)		Date Feb 6	20c. L	ocation - City o	r Town, State	
∑ <u>E</u>	Pages nent of I ant: If it			5 ☐ Other (Specify				Heart (			2004	1	ıdalk, 1	1D	
Mary M. Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fu	uneral Service Licen	ill-	MOC	5986 <sup>2</sup>	2. Name and Cremat 8717 (	Address tion Green	of Facility and Fun Pastur	eral Al	terr	natives Baltimo:	re. MD	
	1		23a. Part1. Enter to	he disease, or com art failure. List only	plications that ca	used the deat	h. Do not er	ter the mode	ol dying,	such as cardiac	or respiratory a			Approximate Interval Between	
	Physician		Immediate Cause	(Final		A	- EN							Onset and Death	
	/Medical		resulting in death)		Due to (o	or as a conseq									
	Examiner	_	Sequentially list co if any, leading to in	nditions,	b	or as a conseq									
1	bed isit	Examlner	Cause (Disease or	eriying iniury	o) or end	ir as a conseq	juence or):								
m.	sician and burial-transit	xan	that initiated events resulting in death)	S	C. Due to (c	or as a conseq	uence of):								
760	Sicie	a		·	d										
89	leath certificate attending physi	edi													
Box 68	h cert endin use	Z/N	IF FEMALE: 23b. Was deceden		23c. If yes, outc	ome of pregnanth 2 Teta		□Ectopic pre	nancv			İ	23d. Date of d		
B	deat he att	Physician/Medic	in the past 12	S≥tNo		int at time of d		Other (spe					Month	Day Year	
P.O.	res that the de signed by the a l be detached f	Phy	9 Unknown	ficant conditions of		ath his act case	udina ia tha	underhing on		in Dort I	230 Did	tebacce	use contribute	to the cause of death?	,
		á	TYDC		ABETES		-	, -	use giver	in Parti.			2 □ No 3 □		
0.00	w require been sig	etec	1440								24a. Wa			autopsy findings availa	
Rec	has ge 2 s	Completed	- 176	PERTEN	121011						auto perf	opsy ormed?	prior to death'	completion of cause of	ol
70	n: Th		25. Was case rele	red to medical						26. Place of Dea	1 Yes		o 1 ⊔ Y	os 2□ No .	
<u> </u>	Physician: The law requires that the death certificate this certificate has been signed by the attending phyrral director, page 2 should be detached for use as the	To Be	examiner?		Hospital: 1 □ In	patient 2	ER/Outpatie	ent 3 DOA	Other		lome 5 ☐ Res		6 □Other (Sr	ecify)	
o			27. Manner of Dear	th	28a. Date o	·	28b. Time Injury		Bc. Injury		28d. Describe			,	
io	nding Path.	atlo	1 Natural 2 Accident	5 Pending investigation	n	1, Day 1001)	milary	М		es 2□No					
Division of Vital Becords.	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	289. Place	of Injury - At h	ome, farm, s fy)	treet, lactory,	office		28f. Location City or To			Rural Route Number,	
_	spital ours a neral i		29a. Certifier	1 Certifying Ph											
	n 24 fr ne Fui ne Fui	edical	(Check only one)	2 ☐ Medical Exar	niner: On the ba and mann		ation and/or i	nvestigation, i	in my opi	nion, death occu	rred at the time	, date an	nd place, and d	ue to the cause(s)	
	To th withir To th comp	Me	29b. Signature and	d title of certifier					License					nth, Dey, Year)	
	1		1/2	1	M.D			D	000	59107		02	-05-	2004	
	1		30. Name and add	ress of person who				, Print)	26	500 L1	BERTY	HE	164751	Trens	
			FALU	UMA, V	NESTAD	& MEO	TCAL (	Roup	B!	MIImor	28	MD	2121	5	
	Sta Registr		31. Date tiled (Mor	UMA Vear)	6 2004	Sylvinage Sign	alui e	Los	18 9						

State of Maryland / Department of Health and Mental Hygiene

				Otate of Maryland		ertificate of			g. No.	U	03403
	Physici	an	1. Decedent's Name (First, Middle, La	- NeLs	2 A	)		2. Date of Death	Day o	Year	3. Time of Death
	/Medic Examir	cal	4a. Facility Name (If not institution, give	<del>-</del>	OI.		4b. City, Town, or I	ocation of Death	大さ の 4c. County	of Death	0010
	Examil	iei	WESTERN CON	rectional Ir	isti	tution (	CUMBE	PRLANK	A	LLE	BANY
	Funeral Director		5. Social Security Number  214-34-2074  Usual Residence of Decedent	ex 7. Age (In yrs. last	t birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth	(dar) 1934	9. Birthplac Country)	e (State or Foreign unk
	nyland how		10a. State 10b. County	10c. City, T	own or I	Location					Inside City Limits
	he Ma	ecto	MD Allegan	y Cre	sapt			1.1			1 ☐ Yes 2√ No
	ath with t s 23a or 2 mat be n	Funeral Director	13800 McMullen I				21502		g. Citizen of V USA		
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23a or 28a-1 show any injury or other traumatic evant, the Maccal Examiner must be notified an once.	ā	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U,S. Armed Forces?  1	nk 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No		pecity Yes or No- o Rican, etc.)	Blac	e - American k, White, etc. white	
5-0	netur	eted	15. Decedent's E (Specify only highest gra		6a. Dec	edent's Usual Occup e kind of work done DO NOT use retired	pation during most of wor	king unk 1	6b. Kind of Bu	ısiness/Indus	itry unk
712	withir Bene. than	Completed	Elementary/Secondary (0-12) unk	College (1-4or 5+)	1110.	DO NOT use retired	u)				
Maryland 2	id be filed ental Hyg ked other ic evant,	To Be C	17. Father's Name (First, Middle, Last	)		unk	18. Mother's Nan	ne (First, Middle, M	aiden Surnam	e)	unk
lary	2 shou and M is mar sumat		19a. Informant's Name/Relationship (		19b. Mai	iling Address (Street	and Number or Ru	ral Route Number,	City or Town,	State, Zip Co	ode)
e, ≥	1 and Health em 27 ther tr		Western Correcti		138 e of Dist	00 McMu11	en Hgwy (	resaptown	n, MD 2	21502 City or Town	State
Baltimore,	t. Pages tment of tant: if its fury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🖾 Other (Specification of the control of the contr	Removal from State (v) in state	etery, cr	ematory or other plac					
Ba	Depermine Depending Important in processing		21. Sig. tur. J Fyneral Servy Lices RONALO S.	111/ pac	I	22. Name and Addre State Anat Baltimore,	MD 212	01		ore, M	D 21201
			23a. Palt1. Enter the disease, or comshock, or heart failure. List only	plications that caused the death. I one cause on each line.	Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Int	oproximate terval Between nset and Death
	Physician /Medical		Immediate Ceuse (Final disease or condition	a CARDION	14	DOATH	1			2	Years
	Examiner		resulting in death)	Due to (or as							16015
7	cuted nd ransit	Examiner	Sequentially list conditions.	b. CONGESTIV Due to (or as	e a conse	equence of):	FAL	LURE			1ears
68760,	ortificete be executed ing physician end e as the buriel-transit	edical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. ATRIAL Due to (or as	E conse	11010	LATIC	ο <i>N</i>			2001
9 xo		2	resulting in death) Last	d						1	
$\mathbf{\alpha}$	es that the death ce igned by the attendi be deteched for use	by Physician/	Part II. Other significent conditions of	contribution to death but not reculting	on in the	underlying cause giv	en in Part I	23h Did toh	2000 USB 001	tribute to the	e ceuse of deeth?
O.	at the c	Phys	CAPO	contributing to death but not resulting	ig iii tilo	andenying cause giv	on are are i.		2 □ No		
l,	res this signed I be de		Car.D.					24- 14		24h Word	autopsy findings
COL	The law requires that the death ete has been signed by the atter page 2 should be deteched for t	Completed						24a. Was an perform	autopsy ed?	availal	ble prior to letion of cause
æ	The lay	mo						1□ Yes	2×100	1 □ Ye	~
/ita	ortifice actor, p	Be	25. Was case referred to medical examiner?	Diam'r.		100		th (Check only one		•	
<del>6</del>	Physician: this certific ral director,	<u>۲</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpation		4 La Nursing n	ome 5 Residen	,		W,CT
<u>0</u>	Attending or death. ector: After by the fune	ation	1 Natural 5 ☐ Pending investigatio	(Month D Year)	Injury	1 Wor	rk? Yes 2∐No	W/	4		
Division of Vital Records, P.O.	or Atter efter deg Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		, farm, s	street, factory, office		28f. Location (Stre City or Town,	eet and Numbe State)	er of Rural Ro	oute Number,
	To the Hospital or Attending Physician: The law within 24 hours effer death.  To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	edical Co		nysicien: To the best of my knowle miner: On the basis of examination and manner stated.							
	vithin 2 Fo the	Med	29b. Signature and title of perillier	and mainer stated.		29c. Licens	se number	29	d. Date signed	(Month, Day	v, Year)
			Voc	cean V		00	8377	7	1- 2	8.0	2
Κ,			30. Name and address of person who	completed cause of death (Item 23	Ва) (Туре	e, Print)	91	02 Se	Lero	120	CHABRE
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	9 /		-/-		y a we	~~	- 4-11 parts
	Registr		FEB 0 6 200	4 plant so so	A STATE OF THE PARTY OF THE PAR	3461.					

State of Maryland / Department of Health and Mental Hygiene 1131 111. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Elizabeth Newton January 21, 2004 2220 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2 N F 86 Director 569-03-9548 August 25, 1917 New York Usual Residence of Decedent 10a. State Show 10b. County 10c. City. Town or Location. 10d. Inside City Limits item 27 is marked other than "naturs!", or Items 23e or 28e-f show other traumatic event, the Macincal Expiration number to notified at Yes 2 No MD Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 International Drive 20906 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXIII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2/1XNo Specify Specify: 3 Widowed 4 X Divorced white 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busines-Andustry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Gov. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event 900g. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William D. Phillips Gladys Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Springfield Avenue, Summit, NJ J.C. Phillips/ Brother 3altimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2/4/04 Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD 4 Donation 5 Other (Specify) Baltimore Crematory at LP <sup>22</sup> Name and Address of Facility Simple Tribute Funeral and Cremation 1040 Rockville Pike Rockville, MD 20 21. Signature of Funeral Service Licensee Center 0852 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical use as the attending IE EEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) P.0. sate has been signed by the page 2 should be detached in 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 🗌 No 3 ☐ Probably 4 🖟 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 21110 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) SILVER SPREAG IMP 31. Date filed (Month, Day, 6 2004 32. Registrar's Signature State FEB Registrar

	1	= For State Registrar		State of M		Cer	tificate	of Dea	th	,	Reg. No.			400
ician			e <i>(First, Middle, L</i> asi Phong	" Nhu	1	Nguy	en			2. Date of D Month Janua:	Day	Year	3. Time of	
dical niner			f not institution, give			9 1	4b. City, Tow	vn, or Locati	on of Death	variua		2004 ounty of Deat	6:00	РМ
	ı		and Baltir				Coll	ege Pa	ark				George's	5
al or		5. Social Security N 586-44-			ge (In yrs. Ia:	st birthday) Yrs.	If Under 1 Y Months Da	ear If Una	der 24 Hrs. rs Min.	8. Date of B	rth 196	9. Birt V 1	thplace (State of puntry) etnam	or Foreign
	-	Usual Residence of 10a. State	Decedent 10b. County		10c City	Town or Loc	ation						104 Inside G	
ō		VA	Fairfax	ζ		rfax	ation						10d. Inside Ci	
Director	-	10e. Street and Nur		-	1 - 4 -		10f. Zip Cod	de			10n. Citize	n of What Co		71
Ö		13813 S	pringsto	ne Driv	70		2012				U.S.		ountry :	
Funeral	-	11. Marital Status	pringbed	12. Was Deceden Armed Forces	t Ever in U.S.	. 13. W	1		Origin? (Sp	ecify Yes or N Rican, etc.)		. Race - Ame		
			ied 2□ Married	1 Yes 2 X			Yes, speciny o ☐ Yes 212			Hican, etc.)		Black, White		
d by		3 Widowed		Year or Dates:								овсіту:	Asi	.an
Completed			15. Decedent's Edu ify only highest grad	lcation le completed)		(Give k	ent's Usual Oci and of work do O NOT use re	one during n	nost of work	ing		of Business/		
mo du		Elementary/Seco	ndary (0-12)	College (1-4or		_	natio		hnol	2017		versi Maryla		
a		17. Father's Name	(First, Middle, Last)		1.4	IIIOII	nacio:			э (First, Middle			anu	
ToB		Hai Ngu	yen					Bi	ch-Kl	hue Ng	uyen			
			ame/Relationship (T)							al Route Numb				
	- 1-	Bich-Qu 20a. Method of Disp	yen Nguy	en (sis	ter)	13813	3 Spr	ingst	one I	Drive,	Clift	con, V	A 2012	4
		* 4 ☐ Donation	☐Cremation 3 ☐F 5 ☐Other (Specify) neral Service Licens Makes		·	newa.	atory or other L1 Men Name and Ac udon P 20 Wil	nory ddress of Fa	cility			nassas Marv	s, VA land 21	229
il r	l	23a Partt. En 4 th shock, or near Immediate ( a se ( disease or c indition resulting in death)		aMu	d the death. line. Lip/ s a conseque	Po not enter	the mode of	dying, such	as cardiac (	or respiratory a	rrest,		Approximate Interval Bety Onset and D	e ween
Examiner	L	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or that initiated event resulting in death) L	riving injury	с.	s a conseque									
Physician/Medical		F FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown	months?	d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3□E	ectopic pregna Other (specify				23d	. Date of deliment		'ear
þ	' '	Part II. Other signifi	icant conditions cor	ntributing to death t	out not resulti	ng in the und	lerlying cause	given in Pa	rt I.	23e. Did 1			the cause of de	
Completed												4b. Were aut prior to c death?	topsy findings a completion of ca	available ause of
o Be	-	25. Was case referr examiner? 1X Yes 2 ☐ I		lospital:	CO.	1/0		Oth		(Check only				
on: T	2	27. Manner of Death	140	28a. Date of Inju	ury 28	VOutpatient Bb. Time of Injury	28c. li	njury at Work?	2	me 5□Resi 28d. Describe Pedeotri	now injury o	curred	ivat sc	ene
ertificati		Accident 3 Suicide	6 Could not be determined	28e. Place of In	jury - At home				- I	28f. Location /	Street and N	umber or Rui	ral Route Numb	0er. ~
444		4 Homicide		building, e	ic. (Specify)	treet				City or To	vn, State)	4 t b	0.0	MD
Cer						11.661			1.6	Xuehec.	OLD BOOK	tilulers Al	ve. P.G.L	yente.

Division of Vital Records, P.O. Box 68760, To the Hospital o within 24 hours aft To the Funeral Di completely filled in

Baltimore, Maryland 21215-0036

29a. Certifier

Quebec and Baltimore Ave. P.G. County 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

January 09, 2004

State Registrar

Medical Ce

31. Date filed (Month, Day, Year)
FEB 0 6 2004

30. Name and address of person who co



who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

		For State Registrar	State	of Maryla	•	artment of H		ind Me		ene 2 ()	No. of the last of	03406
Dhysisia		1. Decedent's Name (First, Middle	, Last)						2. Date of Death Month	Day	Year	3. Time of Death
Physicia /Medic		Anna Pleva				45 Oh T	l continu a	4 Dooth	January	12, 200		2:20am M
Examin	er	4a. Facility Name (If not institution Potomac Valley Nur		umber)		4b. City, Town, or Rockvil				4c. County		ntgamery
Funeral Director		5. Social Security Number 196–50–7786	6. Sex 1 □ M 2 <b>½</b> F	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 1	Year) , 1918	9. Birthp Cour	place (State or Foreign htry) hoslovakia
D ,		Usuel Residence of Decedent  10a. State 10b. County		100	City, Town or Lo	cation					1.	10d. Inside City Limits
aryla •hov	ō		ette	100.	Oity, TOWN OF LC	Vanderbilt						1 ☐ Yes 2 🔯 No
the A	rect	10e. Street and Number			-	10f. Zip Code		-	10	g. Citizen of W	/hat Cou	ntry?
th with 23e or	Funeral Director	42 Maple Drive					19	5486			US	A
or dea	uner	11. Marital Status	Armed	cedent Ever in Forces?	1 U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Orig n, Mexican	gin? (Spec , Puerto P	cify Yes or No- lican, etc.)		- Americ k, White,	can Indian, etc.
rs afte	by Fi	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	ied 1 Tyes If Yes, 0 Year or	3 2 No Sive Dates:		1 ☐ Yes 🏋 No	Specify:			Specify		white
2 hours	ted	15. Deceden	t's Education	4)	16a. Dece	dent's Usual Occupa	ation	of workin	g 10	6b. Kind of Bu	siness/In	dustry
ithin 7	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT use retired	)	, <b>NO</b>				
ified within 72 hours after death with the Maryland Hygiene. Hygiene. Then "natural; or Iteme 23e or 28e-f show ent, it a Medical Exaction must be recilified at		17. Father's Name (First, Middle,	Last)		Ho	memaker	18. Mothe	r's Neme	(First, Middle, Ma		n Horr ∍)	e
should be in a Mental is marked or imatic even	To Be	Stephen Sinal	,						ry Pagur			
is 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene 1. The file of the file of	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street a	and Numbe	r or Rural	Route Number,	City or Town,	State, Zip	Code)
and 2 ealth a m 27 ls		Patricia Sams /	Daughter	- Jan		31 Brink Ro	ad Gen					
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny Injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		m State		natory or other plac				Oc. Location -		
it. Pa urtmen rtant: njury		* 4 □Donation 5 □ Other (S 21. Signature of Funeral Septice				Cemetery J				erryopol	15,	PA
permit. Departmine imports eny inju			VICU	F. 100		Name and Addres harles L. S OUL Last Fo	tevens	Funer	al Home, altimore :	Inc. Maryland	212	30
Physician /Medical Examiner  per particle and per particl	Ilcal Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or mus) that initiated events resulting in death) Last	a. Due to Due to C.	o (or as a cons	) E YY E/ sequence of):							Interval Between Onset and Death  Con Yellu
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Livi	outcome of pre birth 2 F gnant at time o	etal death 3	Ectopic pregnancy Other (specify)				23d. Date Mor		ery Day Year
us, r luires that n signed b	b	Part II. Other significant condition	ons contributing to	death but not	resulting in the u	nderlying cause give	en in Part I.			_	ibute to ti 3	he cause of death? pably 4 Munknown
The law rec	Completed								24a. Was an autopsy perform	ed?   d	Vere autorior to co eath?	opsy findings available impletion of cause of
clan: ertifica	Be (	25. Was case referred to medica examiner?				0.5			(Check only one			
Physi this o	2	1 Yes 2 XNo		☐ Inpatient 2 te of Injury	2 ER/Outpatier 28b. Time o				ne 5 🗆 Residen 8d. Describe hov			ý)
ding th. : After	tlon	1 Natural 5 Pendir	ng (M	onth, Day Year	r) Injury	Work	k? Yes 2 □ 1			,,		
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ce of Injury - A ilding, etc. (Sp	at home, farm, str ecify)	eet, factory, office		2	8f. Location (Stre City or Town,		or Or Rura	il Route Number,
ne Hospita n 24 hours ne Funera pletely fille	Medical C		Examiner: On the			h occurred at the time vestigation, in my of						
To ti within To ti	M	29b. Signafore and title of certifie	All	nal	080 M		number 82	62		d. Date signed	(Month,	Day, Year)
V		30. Name and address of person  DAA ME  31. Date filed (Month, Day, Year,	NOHIR	ATT 2 Registrar's Si	A 240	Print) Resec	ird	, Bi	VD Su	ite 3=	R 0 0	10 roszo
Sta Registi		FEB 0 6	2004	interes.	15 pm	selle)						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 113417 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day IRMA PENCE FEBRUARY 4,2004 3:35P

N/A

Birthplace (Stete or Foreign
Country)

10d. Inside City Limits

1 X Yes 2 □ No

MARÝLAND

WHITE

21286

Day

2 No

3 Probably

1 🗆 Yes

Year

4 Unknown

Month

Approximate Interval Between Onset and Death

**Physician** /Medical Examiner

4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 6401 LOCH RAVEN BLVD APT. BALTIMORE CITY 826 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yeer) 3/27/1912 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2√ F 91 Yrs. Director 217-01-3365 Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10a. State 10b. County itams 23a or 28a-f show the Medical Examiner must be notified at by Funeral Director MD N/A BALTIMOE CITY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21239 USA APT. 826 6401 LOCH RAVEN BLVD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flam any injury or other traumatic event, the Medical pages. 1 ☐Yes 2 XNo 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CHARLES E. MORAN PEARL BALANCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WHITE HALL, SON 2820 GARRETT ROAD MD RONALD J. LEWIS 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2/9/2004 CATONSVILLE, MD METRO CREMATORY, INC. 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21. Signature of Eugeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Dou to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ō 4 ☐ Pregnant at time of death 5 Other (specify) detached P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death bullinot resulting in the underlying gause given in Part I. Records, 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No certificate 1 Yes of Vital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCHNE Yes 2□ No 2 2 ☐ ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Alter Division Injury Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. Diractor: / 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a the Hospital 29a. Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier O.C.M.E. FEBRUARY 5,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar

J. Laron Locke M.D.

FEB 0 6 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - State Amend Item#7,8,2	State of M ObperFHG828	aryland / Dep 2/10/04EW <sub>Ce</sub>	artmen <i>rtificat</i>	t of H e of L	ealth a Death	nd M		giene g	:004	0040(
2	Physic /Medi		Decedent's Name (First, Middle, Las.						_	2. Date of Dea Month		Year O4	3. Time of Death 7;20 PM
	Examine Funeral Director		5. Social Security Number 6. Se	Drive	e (In yrs. last birthday) <del>92</del> - 74 Yrs.	G1	.enwo	od  If Under 2  Hours		8. Date of Birt (Month, Da		Howard 1929. Birth Cou	place (State or Foreign
	- 0%.	ō	Usual Residence of Decedent  10a. State 10b. County  Md Howar	A	10c. City, Town or Lo	ocation					<del>/-1/1</del> 1		Md  10d. Inside City Limits  1 ☐ Yes 2 ☑ No
9	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Exeminer must be notified at	Funeral Director	10e. Street and Number 2864 Hunt Valley  11. Marital Status 1 Never Married 2 Married	Drive  12. Was Decedent Armed Forces?	No	Was Deced If Yes, spec	2173 lent of His	spanic Orig n, Mexican,	in? (Spe Puerto	ecify Yes or No- Rican, etc.)	U S	of What Cou A Race - Americ Black, White,	ntry?
Maryland 21215-0036	filed within Hygiene. other than *	e Completed by	3 Widowed 4 Novorced  15. Decedent's Edit (Specify only highest grade  Elementary/Secondary (0-12)  8th grade  17. Father's Name (First, Middle, Last)	If Yes, Give Year or Dates:	16a. Dece (Give iife.	dent's Usua kind of wor DO NOT us neral	l Occupa k done di e retired)	tion uring most		ng (First, Middle,	16b. Kind of Balt Gaint	imore Business/In	
	nd 2 should be lith and Menta 27 is marked r traumatic ev	To Be	Richard D. Powel  19a Informant's Name/Relationship (7)  Barbara Golden -	rpe, Print)	1		(Street a	Anı nd Number	na B or Rura	ell Mea	de r, City or To	wn, State, Zip	
Baltimore,	permit. Pages 1 a Department of Hea Important: If item any injury or othe once.		20a. Method of Disposition  1 🕇 Burial 2 □ Cremation 3 □ F  1 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service signature		cometery, cres	natory or of natory or of n Fo	ne of ther place rest	Vet <del>2</del>	2/10 2/9/	2004	20c. Location	on - City or To	own, State
Sec.	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or composhock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. En all Underlying Cause (Disease or Injury)	Due to (or as:	the death. Do not entitle.  If are multiple a consequence of:  Cancer,	w w	of dying	, such as ca				e Balt	Approximate Interval Between Onsel, and Death I Clay
.O. Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical Exar	resulting in death) Last		a consequence of):   of pregnancy 2 □ Fetal death 3 □	Ectopic pre	egnancy	410				Date of delive Month	ry Day Year
<u> </u>	aw requires is been sign 2 should be	Completed by Pl	Part II. Other significant conditions con hypothyroidisc		ut not resulting in the ur	nderlying ca	use giver	in Part I,		23e. Did tol	n 24	3 Prob	e cause of death?  ably 4 Unknown  by findings available appletion of cause of
Division of Vital Records,	ysician: is certifica director. p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	lospital: 1 ☐ Inpatier			Other	4 🗆 Nurs	ing Hom	perform	ned? 2 DXNo e) ence 6 □0	death? 1 ☐ Yes  Other (Specify	2 □ No
Division	D 0 0	Certification;	2 Accident 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injur (Month, Day 28e. Place of Inju- building, etc	ry - At home, farm, stre	М		at es 2⊡No	>	8d. Describe ho 8f. Location (St City or Town	reet and Nu		Route Number,
e .	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: All completely filled in by the fur	Medical Co	29a. Certifier (Check only one)  1 ★ Certifying Physical Examination (Check only one)  1 ★ Certifying Physical Examination (Check only one)	sician: To the best oner: On the basis of and manner state	of my knowledge, death examination and/or invited.	estigation,	in my opir	nion, death	place, a occurre	d at the time, da	ate and plac	e, and due to	the cause(s)
	T with		▶ Marshell	mpleted cause of de	eath (Item 23a) (Type, I		D35		5	Balti		5/04	
	Sta Registr		31. Date filed (More Bay) 798) 200	A Registra	r's Signature	west	eena	str	eet	Balti	nore	MDZ	2(201

			For State Registrar AMEND TTEM #17			epartment of H JH Certificate of I		lental Hygie. Reg.	L, U U	: 03400
	Physicia	an	Decedent's Name (First, Middle, Last)     Manubhai Amba	ılal Pate	1_			5-1	Day Year	3. Time of Death
,	/Medic Examin		4a. Fecility Name (If not institution, give s	treet and number)		0	Location of Death	te bruery	4c. County of Dear	th
	Funeral Director		5. Social Security Number 6. Sex	Y. alle	In yrs. last birth	1111111111111111	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Augus t 30		thplace (State or Foreign ountry)
	yland now		Usual Residence of Decedent  10a. State 10b. County		0c. City, Town					10d. Inside City Limits
	he Mar 28a-1 st	Director	Maryland Baltimore		Baltimo	re		100	Citizen of What Co	1 Tyes 2 No
	23a or 2	al Dir	6612 Hunters Wood	Circle		21228			nited Sta	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other then "natural", or itams 23s or 28s-1 show other treumatic event, the Medical Examiner must be incitined at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	<ol> <li>Was Decedent Even Armed Forces?</li> <li>1 ☐ Yes 2 X No If Yes, Give Year or Dates:</li> </ol>	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spi in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Pac	
21215-0036	in 72 hou n "nature legicel E	Completed	15. Decedent's Educ (Specify only highest grade	completed)		Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	during most of work.		. Kind of Business	
212	e filed within at Hyglene. I other then "		Elementary/Secondary (0-12) 12	College (1-4or 5+)	Er	ngineer	19 Mathada Name	Ba (First, Middle, Main	altimore	City
Maryland	ild be fil lenta! H ked otl ic even	To Be	17. Father's Name (First, Middle, Last) AMBALAL PATEL 13. 12. 14. 14. 14. 14. 14. 14. 14. 14. 14. 14				Shardab		ien Sumame)	
Mary	12 should and Ministreeumati		19a. Informant's Name/Relationship (Type Hamang M. Patel-S			Mailing Address (Street)  O East Aver				
Baltimore, I	8 = 5		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)		20b. Place of	Disposition (Name of crematory or other place re Grematory Park	(a)	Date 200	. Location - City or	Town, State
Baltir	permit. Pa Departmer Important: any injury once.		21. Signatur of uneral Service Visions	Morson		22. Name and Addres	ss of Facility Loue	don Park	Funeral H	lome Maryland 2122
AC.	Miles Late Miles		23a. Part 1. Enter the disease, or complishock, or heart failure. List only of	ations that caused the cause on each line.	ne death. Do no	ot enter the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence o	rephalopa	thy			3 days
	e.	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence o	1):				
68760,	icate be executed physicien and s the burial-transit	edicai Examiner	Cause (Disease or Injury that inflated events resulting in death) Last	Due to (or as a	consequence o	f):			H	
.O. Box 68	death certil a attending od for use a	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3 Ectopic pregnancy 5 Other (specify)	774 40 40		23d. Date of de Month	livery Day Year
₽	quires that the d in signed by tha uld be detached	by	Part II. Other significant conditions con	tributing to death but	not resulting in	the underlying cause giv	en in Part I.	23e. Did tobac 1 ☐ Yes		o the cause of death?
Vital Records,	The law requires ate has been sign page 2 should be	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of .
	ician: certific ector.	o Be (	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	2 🗆 EB/Out	patient 3 DOA Oth	0.0	me 5 Residence	6 Other (Spe	acity)
ion of	ding h. After tune		27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day )	28b. Ti	me of 28c. Injur		28d. Describe how i		cuy)
Division	al or Atten s after deat il Director: id in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.		m, street, factory, office		28f. Location (Stree City or Town, S	t and Number or R tate)	urai Route Number,
4	To the Mospital or within 24 hours after To the Funeral Direction completely filled in the compl	edicai			xamination and	death occurred at the tir Vor investigation, in my o				
)	with To t	Σ	29b. Signature and title of certifier	12		29c. Licens	e number	29d.	Date signed (Mont	th. Day, Year)
	V		30. Name and address of person who co			1	2077 N 1	I Fe	Drugsy,	1022
k.	Sta		31. Date filed (Month, Day, Year)	327 Registrar	's Signature	ton Ave	· · · · · · · · · · · · · · · · · · ·	timore,	ANCE &	1227
	Registi	ar	FEB 0 6 2004	J. College Co.	15 1					

Patel, Manubhai A

			1 - For State Registrar	State of Maryla	ınd / Depa <i>Cer</i>	artment of F tificate of	lealth and <i>Death</i>		giene 2 (	104	0341
	Physic		Decedent's Name (First, Middle, Last)     Ethna McGowan B	Prah 1				2. Date of De Month	ath	žůvy	3. Time of Death
	/Med Exami	ner	4a. Fecility Name (If not institution, give s	treet and number)	s. last birthday)	4b. City, Town, or Pout 19	r Location of Dea	th	4c. Coun	ty of Deeth	Sloce (State of Service
	Funeral Director			M 257 E	7 Yrs.	Months Days	Hours Min		y, Yeer) 1906		olece (State or Foreign otry) 11and
	e Maryland a-f ehow	ctor	10a. State 10b. County  Maryland Baltimor		Cato	nsville				1	0d. Inside City Limits
	with the a or 28	Director	10e. Street and Number 715 Maiden Choice	e Iano		10f. Zip Code 21228			10g. Citizen of		itry?
36	d within 72 hours after death with the Maryland giene rrithen "naturel", or itema 23a or 28a-f show the Medical Examiner must be notified at	by Funeral		2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	H	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (: an, Mexican, Pue Specify:	Specify Yes or No nto Rican, etc.)	- 14. Ra	S.A.	elc.
1215-00	within ane then	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give life. E	ent's Usual Occup kind of work done OO NOT use retired autician	during most of wo	orking	16b. Kind of E		dustry
nd 2	other other	Be	17. Father's Name (First, Middle, Last)		be	autician	18. Mother's Na	me (First, Middle,		Salon	
ryla	should be ind Mental i marked o umatic eve	5	George Kirby  19a. Informant's Name/Relationship (Type	ne Print)	19h Mailin	g Address (Street		he Speck			
Baltimore, Maryland 21215-0036	os 1 and 2 and Health ar item 27 is		George V. McGowan  20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ Re	(Son) 20b. emoval from State	400 Q Place of Dispos cemetery, crem	uarter ( ition (Name of atory or other place	Creek Dr	ive Quee		MD 2	1658
Baltin	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		22. Wi	sh. Crema Name and Addres tzke Fund	ss of Facility eral Hom	e of Cat	Laurel, onsvill	e. In	С.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications, or heart failure. Ust only on Immediate Cause (Final disease or condition resulting in death)	cations that caused lhe dece cause on each line.  ASCUD  Due to (or as a conse	ath. Do not ente	30 Edmon	dson Ave	nue Cato	nsville	, MD	21228 Approximate Interval Batween Onset and Death
68760,	ficate be executed physicien and is the burial-transit	edical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classes of Injury) that initiated events resulting in death) Last	Due to (or as a conse							
P.O. Box 6	death certi e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ic. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 1	Ectopic pregnancy Other (specify)			1	ite of deliver	ry Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions conditions Hypertensio		sulting in the und	derlying cause give	en in Part I.		obacco use cont		e cause of death?
Division of Vital Records,	ician: The law r certificate has be rector, page 2 sh	Completed				-		24a. Was a autop perfor 1 Yes	med?	prior to com death?	sy findings available apletion of cause of
<u> </u>	ysician s certif directo	To Be	25. Was case referred to medical examiner?  1 Tyes 2 No Ho	ospital: 1 ☐ Inpatient 2 0	ER/Outpatient	3□ DOA Othe	· Pi	ath (Check only or			
sion of	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification; T	27. Manner of Death  1. Active 1 5 Pending investigation	28a. Dale of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury Work	4   Nursing F	lome 5 ☐ Resid 28d. Describe h			
Ď Š	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		3 Suicide 6 Could not be determined	28e. Place of Injury - At the building, etc. (Special Control of the building) and the building of the buildin	ify)			28f. Location (S City or Tow	n, State)		
7	the Hosp in 24 hou the Fune pletely fi	edical	29a. Certifier Check only one)	cian: To the best of my kn er: On the basis of examin- and manner stated.	owledge, death ation and/or inve	occurred at the tim estigation, in my op	e, date and place pinion, death occu	, and due to the corred at the time, o	ause(s) and ma late and place,	and due to t	ted. the cause(s)
)		Σ	29b. Signature and title of certifier	× n	0	29c. License	number 533/2		Pebrua.		
	B		30. Name and address of person who con Michelle Henggele	npleted cause of death (Ite	m 23a) (Туре, Р 900 Се	rint) afon A	venue,	Bal	timore	, MO	21229
	Sta Registr		31. Dale liled (Month, Day, Year)	32. Registrar's Sign	6	CARE D					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 8 per fh 9845 7-15-05 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death , Month 1. Decedent's Name (First, Middle, Last) Yeer **Physician** 23:00 PM 2004 KORA 31 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Buttmore Uty
Under 1 Year If Under 24 Hrs. 9. Date of Birth
Hours Min. (Month, Day, Year) of Baltimore Suran Hospital Barbara Ridohick Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months -49 1 🗆 M Mar. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or Itams 23a or 28a-f ehow or other traumatic event. The Medical Examiner must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race -Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates: "natural", When Known as 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) and Mental Hygiene. (0-12)lephone GKHDE 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number, or Flural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health as Important: If Item 27 is eny injury or other trau once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal Irom State
4 Donalion 5 Other (Specify) amestown aughin ( 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Greeneturial 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart lattere. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Bleomycin-induced Physician /Medical Due to (or as a consequence of) Examiner Itada Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, , page 2 should be 3 ☐ Probably 4 ☐ Unknown 2 No 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 1 Yes 2 ☐ No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) Hospital: 1 Yes 2 No 1 Inpatient 3 DOA ဥ 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funarel Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only опе. å ‡ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie COC D who completed cause of death (Item 23a) (Type, Print) and address of person 30. Name Shumuza Baltimore Judi D.0 sunar 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar 0 6 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician Catherine M. Rettaliata 4b. City, Town, or Location of Death 4c. County of Death 10:06AM /Medical 4a Facility Name (If not institution, give street and number) Examiner St. Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 22, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 🛛 F 217-18-2279 79 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 United States 3 Benjamin Way 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give ↑ Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3aitimore, Maryland 21215-0020 ੬ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mildred Inez Buffington George Edward Stone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3 Benjamin Way, Ellicott City, Maryland 21043 Susan Rettaliata / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 2/6/04 Elkridge, Maryland Meadowridge Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Myocardia ( Infarction Immediate Cause (Final disease or condition resulting in death) /Medical Physician/Medical Examiner attending physician and I for use as the burial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last coronary arrery atheroscleros. s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown chronic obstructive þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Preumonia 1 X Yes 2 □ No 1 Noves 2□No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 5 Pending il or Attending i after deeth. I Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 1 (W Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 056226 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael S. Ballo M.O 900 cuton Ave Baltimore 32. Registrer's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

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ompleted	15 Decedent's F	If Yes, Give Year or Dates	:		1 ☐ Yes	2A No	Specify:			Sp	pecify: W	hite
E C	(Specify only highest gr	ducation ade completed)		16a. Deced	kind of wor	rk done d	urina most i	of workii	ng l	16b. Kind	of Business/	industry
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מ	17. Father's Name (First, Middle, Last										en Sumame)	
2				10h Mailie	A el el	(Ctroot o					Cto to 7	Fin Control
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			20b. Pla	ce of Dispo	sition (Nan	ne of	1		7000			Town, State
	1 Burial 2 Cremation 3	Removal from Stat	в Сел	metery, cren	natory or o	ther place	•)				•	
-			1.1	-22	. Name an	d Addres	s of Facility		655 E			
1	Kona Ia S.	Wade Di	ectir						655 W.	Balt:	imore	Street
LXG	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or a	URO IS a conseque RES	ence of): PrRf ence of).		RY	DIS	TRE	-22			Interval Between Onset and Death  5 DAY S  4 DAY S
ysicianymedi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	1 Live birth	2 🗍 Fetal o	déath 3□						23d	. Date of deli	very Day Year
	Part II. Other significant conditions	contributing to death	but not result	ting in the ur	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
									1 □ Ye	s 2 N	io 3□Pro	obably 4 Unknown
200											4b. Were au	topsy findings available
									perform	ned?	death?	ompletion of cause of 212 No
D							26. Place o	f Death			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpa	tient 2 E	R/Outpatien	t 3 00	A Othe	r: 4 🗆 Nurs	ing Hon	ne 5 Reside	nce 6	Other (Spec	ify)
		28a. Date of In	jury 2		2	8c. Injury	at ?					
3	2 Accident investigation	n	,,	,,	М							
		289. Place of I		ne, farm, stre	eet, factory	, office		2			umber or Ru	ral Route Number,
	29a. Certifier (Check only 2 Medical Exa	nysician: To the bes	of examination	ledge, death	occurred a	at the time	e, date and	place, a	nd due to the ca	use(s) and	d manner as	stated.
	one)	and manner	stated.									
-	29b. Signature and tyre of certifier	AA ~			1			20				
	Aprima					424	1207	10:	1 5 45	NAN	31,	2004
		completed cause of	death (Item 2	23a) (Type, I	Print)							
	medical cer unication, 10 pe completed by Filystral products Examined	19a. Informant's Name/Relationship  Nancy Volpe/o  20a. Method of Disposition  1	19a. Informant's Name/Relationship (Type, Print)  Nancy Volpe/daughter  20a. Method of Disposition  1	19a. Informant's Name/Relationship (Type, Print)  Nancy Volpe/daughter  20a. Method of Disposition  1	19a. Informant's Name/Relationship (Type, Print)  Nancy Volpe/daughter  20a. Method of Disposition    Burial 2   Cremation 3   Removal from State	19a. Informant's Name/Relationship (Type, Print)  Nancy Volpe/daughter  20a. Mathod of Disposition  1	19a. Informant's Name/Relationship (Type, Print)  Nancy Volpe/daughter  20a. Method of Disposition 1	19a. Informant's Name/Relationship (Type, Print)  Nancy Volpe/daughter  20a. Method of Disposition 1	19a. Informant's Name/Relationship (Type, Print)  Nancy Volpe/daughter  20a. Mathod of Disposition 1 Burial 2   Cremation 3   Removal from State 1 A Donation 5   Other (Specify) 21. Signal and Address of Pacific Anatomy of other place) 22a. Part   Enter the disease, or complications that classed the death. Do not enter the mode of dying, such as cardiac o shock or hear failure. List only one cause on each line.  22a. Part   Enter the disease, or complications that classed the death. Do not enter the mode of dying, such as cardiac o shock or hear failure. List only one cause on each line.  22a. Part   Enter the disease, or complications that classed the death. Do not enter the mode of dying, such as cardiac o shock or hear failure. List only one cause on each line.  22b. Part   Enter the disease, or complications that classed the death. Do not enter the mode of dying, such as cardiac o shock or hear failure. List only one cause on each line.  22b. Part   Enter the disease, or complications that classed the death. Do not enter the mode of dying, such as cardiac or shock or hear failure. List only one cause on each line.  22b. Was deendent pregnant in the past 12 months?  1 we so was deendent pregnant in the past 12 months?  22b. Was deendent pregnant in the past 12 months?  1 we so 2 was deendent pregnant in the past 12 months?  22c. If yes, outcome of pregnancy in the underlying cause given in Part I.  22c. If yes, outcome of pregnancy in the underlying cause given in Part I.  22c. If yes, outcome of pregnancy in the underlying cause given in Part I.  22c. Was case referred to medical examiner?  22c. Value birth 2   Partial death   Signal death	19a. Informant's Name/Relationship (Type, Prnt) Nancy Volpe/daughter  20a. Mathod of Disposition 1	19a. Informant's Name/Relationship (Type, Print)  Nancy Volpe/daughter  4.1 Hawk Rise Lane Owings Mills, Mi  20a. Method of Disposition 1. Burst 2   Coremation 3   Removal from State 4.2 Donation 5   Children (Specify)  21. Somewood Fround State 4.3 Donation 5   Children (Specify)  22. Somewood Fround State 4.4 Donation 5   Children (Specify)  22. Somewood Fround State 4.5 Detail (Specify)  23. Part I. Enter the disease, or obligications that charges the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Immediate Cause (Final and Address of Part II underlying Cause)  Beguentially list conditions.  I any, examing to emmediate cause (Final Underlying Cause)  Cause (Disease or night)  1. Sequentially list conditions.  I any, examing to emmediate cause (Final Underlying Cause)  2. Was cause in the past 12 months?  1. Sequentially list conditions.  I any examing in death) Last  2. Due to (or as a consequence of):  2. Due to (or as a co	19a. Informant's Name-Relationship (Type, Print) Nancy Volpe/daughter  20a. Method of Disposition 1 Burial 2 Cormation 3 Removal from State 2 Cormation 3 Removal from State 2 Cormation 3 Removal from State 2 Cormation 3 Removal from State 2 Cormation 3 Removal from State 2 Cormation 3 Removal from State 2 Cormation 3 Removal from State 2 Cormation 3 Removal from State 2 Cormation 3 Removal from State 2 Cormation 3 Removal from State 2 Cormation 3 Removal from State 2 Cormation 3 Removal from State 2 Cormation of Removal from State 2 Cormation o

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 02, **Physician** February ROUSSEY 2004 11:03 p<sup>M</sup> JOSEPHINE MARY /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore n/a 1242 Haverhill Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept.17 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F 215-14-9437 80 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: if item 27 is marked other then "natural", or tiems 23e or 28e-1 show any injury or other traumatic event, the Marical Examilmer: unit be notified at once. 1 Yes 2 No Directo n/a Md. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 1242 Haverhill Road U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 8 Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဂ္ Brocato Mary Cascio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Son) 804 Miner Road, Crownsville, Md. 21032 Vince Roussey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

\* 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 02/07/04 Baltimore, Md. 21. Signature of Fundral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225 Approximate Interval Between Onset and Death 23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thick, or heart failure. List only one cause on each time. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a cor **Examiner** ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed detached for use as the burial-transit Varian the attending physician and Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? 1 ☐ Yes 2€No Month Day Year 4☐Pregnant at time of death 5 Other (specify) <u>о</u>. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown Be Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed?

1 Yes 2 No 1 🗌 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) Hospital: 2 1 ☐ Yes 25 No 1 Inpatient 2 EP/Outpatient 3 DOA the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Salatural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

State of

Maryland / Department of Health and Mental Hygiene		-		
Cartificate of Dooth	Suran	1	5	

						Certific	ate of	Death	Reg	. No.	104	00410
	D		1. Decedent's Name (First, Middle, Last)						2. Dete of Deeth Month	Dey	Year	3. Time of Death
	Physici /Medic		Audrey Hazel H	Radcliffe					February		2004	8:15am
)	Examin		4a Fecility Neme (If not institution, give s	treet and number)				4b. City, Town, or	Location of Deeth	4c. County	of Deeth	
~-	°		109 Woodland Dri					Bel Ai		Ha	rford	
	Funeral		Social Security Number     6. Sex	7. Age (In yr		(rs. Mont	hder 1 Year hs Days	If Under 24 Hrs Hours Min	(Month, Day, Y		9. Birthpla Count	ace (State or Foreign try)
	Director		100-28-5153	(	58	113.			June 13,	1935	Ma	ryland
1	B &		Usual Residence of Decedent  10a. State 10b. County	10c. 0	City, Town	or Location					10	Od. Inside City Limits
	New Year	ō			D - 1	7						1□Yes 2□Ng
	25 19	Director	Maryland Harford  10e. Street end Number		вет	Air 10f.	Zip Code		10g	. Citizen of \	What Count	try?
1	23e or 28e-f show		109 Woodland Dr	ivo			2	1014			USA	
1	items 2	Funeral		2. Was Decedent Ever in	U,S.	13. Was De	ecedent of I	dispanic Origin? (5	Specify Yes or No-		e - America	
5	or its		1 Never Married 2/2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No			specify Cub s 2. No	an, Mexican, Puer Specify:	to Rican, etc.)		ck, White, e	AC.
2	Since The state of the state of	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		10.16	5 2 <b>X</b> 140	эреспу.		Specify		ite
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ני ע	Healt Healt Ther		20a. Method of Disposition		Place of	Disposition (	Name of	ï		c. Location -	City or Tov	wn, State
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	deal	Physician/	Pert II. Other significant conditions con	tributing to death but not re	esulting in	the underlyi	ng cause gi	ven in Part I.	23b. Did toba	icco use co	ntribute to	the cause of death?
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	After ti	ü	27. Manner of Death  Natural 5 ☐ Pending	28e. Date of Injury (Month, Dey Year)	28b. T	ime of njury	28c. Inju Wo		28d. Describe how	injury occur	red	
ה ה	death. ctor: Al	cat	2 Accident investigation 3 Suicide 6 Could not be			M		Yes 2□No	28f. Location (Street	at and think	nor or Bural	l Pouto Number
LINISION	fter d	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	nome, tal	rm, street, 120	стогу, опісе		City or Town,		oer or murar	Houle Number,
4 .	to the hospital or Atlenting Fra within 24 hours effer death.  To the Furerel Director: After thi completely filled in by the funerel	2	20a Cartifier	falen. To the heat of any to	noudadac	deeth coor-	red at the *	me data and al	e and due to the a	ea(e) and m	anner en ch	ated
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	3		30. Name end address of person who co	moleted cause of deeth /It	tem 23e) /	Type, Print\	Doboro	uol+ M	D 1	,		
	b		5601 Loch Rai		(	BA	ith w	Holt, M	Marylo	and	21	239
74	Sta	ate	31. Date filed (Month, Day, Year)	2. Registrer's Sig	neture	0	- 47		7			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 5, 2004 **Physician** 12:04 PM Richardson Lou /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 23, 1905

8. Birthplace (State or Foreign Country)
North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 1□M 21 F 98 Director 217-24-5801 Usuel Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examin ar must be notified at 1 Yes 2 No Director Maryland | Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1107 Mountain Road South 21085 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: Specify: þ ¾□Widowed 4□Divorced White ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Maines Sarah Jane Wolf Hiram nmn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jerrel C. Richardson - Son 206 Contee Court, Joppa, Maryland 21085 item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of important: If any injury or once. Bel Air, Maryland Bel Air Mem. Gardens 2/09/04 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signatury Funeral/Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATURY FAILURE Pnysician disease or condition resulting in death) /Medical BILATERAL PNEUMONIA **Examiner** GXTGN SIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine GBSTIVE HEART PAILURE physician and s the burial-transit BENDOCARDIAL MYOCARDIAL INFARETUON Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě ATKIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed 1LR0S6P318 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 5 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of eath Certification: Division Hospital or Attending Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director; 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

12

DANUSHA SIRITHARA SUITE 206,7505 OSIER DRIVE, TOWSON, MD 212

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 0 6 2004

M		State of Maryland / Dep 1- State of Maryland / Dep Registrar # 23a,pt.II,2/ per me G828		-	_	03417
Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death
/Med	ical	WALTER R. SPENCER	4b. City, Town, or Location of Death	FEBRUARY	1, 2004 4c. County of Death	2:37 P M
Exam	ner	4a. Fecility Name (If not institution, give street and number)  NORTHWEST HOSPITAL CENTER	RANDALLSTOWN		BALTIMORE	m
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Y		lece (Stete or Foreign try)
Directo		217-52-8491 1 ■M 2 F 52 Yrs.  Usual Residence of Decedent	Months Days Flours Will.	May 26,	1951 Mary	Land
land ow		10a. State 10b. County 10c. City, Town or I	ocation		10	Od. Inside City Limits
Man,	to	MD Baltimore Rand	dal1stown			1. XYes 2 □ No
or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?
ath w	rall	4217 Herrera Ct.  11. Marital Status 12. Was Decedent Ever in U.S. 13	21133	positu Voc or No	USA 14. Race - Americ	an Indian
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural; or Items 23e or 28e-f show any injury or other treumatic avent, Ire Medical Examinal must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Never Married 2 Married I Yes 2 No ff Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ■ No Specify:	Rican, etc.)	Black, White,	etc.
21215-0036 solution 72 hours aft giene. or than "natural", or it an Medical Exerci-	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation re kind of work done during most of work		b. Kind of Business/Inc	
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and 2 alth a street treet		Dartagnan E. Spencer/Brother 42			wn, MD 2113	33
of He	1	20a. Method of Disposition 1 ☐ Burial 2 ■Cremation 3 ☐ Removal from State	position (Name of ematory or other place)		c. Location - City or To	
altimore, mit. Pages 1 ar partment of Hea portant: If Item y injury or other		'4 Donation 5 Other (Specify) Metro C	rematory 2-7-0	04 Ca	atonsville,	, MD
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3760, V.  Ite be executed Assician and Assician and Assician and Assician and Assician and Assician and Assician and Assician and Assician and Assician and Assician and Assician and Assician and Assician and Assician and	cai Examiner	23a. Fert1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Interval Between Onset and Death
P.O. Box 687 that the death certificate od by the attending phys detached for use as the	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year
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f Vital Reysician: The is certificate his director, page	BeC	25. Was case referred to medical examiner?		th (Check only one)		
× 50 0	2	1 \( \overline{\text{Yes}} \) 2 \( \overline{\text{No}} \) No \( \overline{\text{Hospital:}} \) 1 \( \overline{\text{Inpatient}} \) P(Outpatient \( \overline{\text{Youtpatient}} \) 28a. Date of Injury \( \overline{\text{Month, Day Year}} \) 28b. Time \( \overline{\text{Injury}} \) 2 \( \overline{\text{Accident}} \) Accident \( \overline{\text{investigation}} \)	of 28c. injury at	ome 5 ☐ Residence 28d. Describe how	ce 6 ☐ Other (Specify injury occurred	/)
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
ne Hospital n 24 hours a	edical C	29a. Certifier (Check only projection)  (Check				
To the within To the comple	Me	29b. Signature and the of certifier	29c. License number O C M E		EBRUARY 2,	•
		30 . And address of person who completed cause of death (Item 23a) (Typ	e. Print)  111 Penn Stree	et, Baltir	more, Mary	land 21201
S Regis	tate trar	31. Date filed (Month, Day, Year)  FFB 0 6 2004  32. Registrar's Signature	i Sparket			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Lucretia H. Shroat February 3, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Broadmead Retirement Center Cockeysville Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 20 F 220-18-4751 92 Yrs. Director Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic svent, the Medical Examiner must be notified at MD Baltimore 1 Yes 2 No Cockeysville Director 10f Zip Code 10g. Citizen of What Country? 10e Street and Number 13801 York Road #361 Taylor Hall 21030 USA Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Affiled Folces: 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ 1 ☐ Yes 2X No Specify: white Š 3 XWidowed 4 □ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Baltimore, Maryland 2121 r than " College (1-4or 5+) Elementary/Secondary (0-12) 12 h and Mental Hygic is marked other th counselor/teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Albert Heisey Veda Eves ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen Magin/niece 4539 Franklin Avenue Western Spring, IL 60558 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 X Donation 5 □ Other (Specify) Signature of Funeral Service RODA Ld 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Mouns Baltimore, MD 21201 art1. Enter the disease, or o molications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immed e Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 3 Probably 1 🗌 Yes 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1∐ Yes 2 No Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 3□ DOA 4 Vursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 7 of in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After Certification: Division 1 Satural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Momicide Hospital within 24 hours a pletely filled 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 38392 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature RBAR 1380 31. Date filed (Month, Day, Year) State Species Registrar

Discretization of December   100, Journal   100, County			20b per Fh,G828,02/10/9	partment of Health and Months	Reg. No.	2004 03419
POTECOTO  DECO	/Medical	William	H. Smith	4b. City, Town, or Location of Death	February Day	4,2004 1215PM
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Physician Medical Superior Function State  Physician Medical Superior Function State State Superior Function State State Superior Function State State Superior Function State State Superior Function State Stat	iryland 2 should be filed ad Mental Hyg marked other matic event, To Be C.	William H.	Smith	18. Mother's Name Sin Od	die Cop	pper
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Physician Medical Examiner    Part   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Character   Case   Case   Character   Case   Character   Case   Character   Case   Case   Character   Case   Character   Case   Character   Case   Case   Character   Case   Character   Case   Character   Case   Case   Character   Case   Character   Case   Character   Case   Case   Character   Case   Character   Case   Character   Case   Case   Character   Case   Cha	Balti permit. Departm Importa eny inju once.	21. Signature of Funeral Service Vicen	L. Russ	22. Name and Address of Facility  10 Sepon L. Puss  2222 WINDOWN A	Fupera ve. Balt	1 Home on Md. 21216
Souwerlaw in items of the image	/Medical	shook or heart failure. List only of Immediate Cause (Final disease or condition	a. Sepsis	enter the mode of dying, such as cardiac	or respiratory errest,	
THE PROPERTY OF THE PROPERTY O		if any, leading to immediate cause. Enter Undertying Cause (Diseese or injury that initiated events	Due to (or as a consequence of):  c. Urinany Tra	ct Infectio	n	
1   Yes   2   No   3   Probably   4   Poffking   24a. Was an autopsy performed?   1   Yes   2   No   3   Probably   4   Poffking   24a. Was an autopsy performed?   1   Yes   2   No   24a. Was an autopsy performed?   1   Yes   2   No   24a. Was an autopsy performed?   1   Yes   2   No   24a. Was an autopsy performed?   1   Yes   2   No   24a. Was an autopsy performed?   1   Yes   2   No   24a. Was an autopsy performed?   1   Yes   2   No   24a. Was an autopsy performed?   1   Yes   2   No   25a. Place of Death (Check only one)   25a. Place of Death (Check only one)   27a. Manner of Death	Geath certific death certific de attending plud for use as I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Fetal death 4 Pregnant at time of death			
25. Was case referred to medical examiner?  1   Ves 2   No	rds, P quires thet an signed b uid be deta		ontributing to death but not resulting in the	underlying cause given in Part I.		
To be the time of	al Reco				autopsy performed?	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Meenakshi Gupta MD C/O Manjland General Hospital	ion of Vita nding Physician ath. r: After this certifi e funeral director etuneral director	examiner? 1	28a. Date of Injury (Month, Day Year)  28b. Time Injury	of 28c. Injury at Work?	me 5 Residence	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Meenakshi Gupta MD C/O Manjland General Hospital	Divis tal or Atta rs after dec ai Director ed in by th	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Meenakshi Gupta MD C/O Manjland General Hospital	the Hosp hin 24 hou the Fune mpletely fill		niner: On the basis of examination and/or	investigation, in my opinion, death occur	red at the time, date and	f place, and due to the cause(s)
Meenakshi Gupta MD % Maryland General Hospital	To To	> 4 Just	2	89516	1	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10 1 1 1 1 A	completed cause of death (Item 23a) (Type C/0 32. Registrar's Signature	manifold Ger	ieral H	ospital .

		1	For State Registrar	State of N	Maryland	-	rtment of H tificate of L		Mental Hy	giene Reg. No.	2004	03420
	_		1. Decedent's Name (First, Middle, L	ast)					2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		Ro	bert W.	Sch	losse	er		Feb	2	2004	6:45р м
	Examin	_	4a. Fecility Neme (If not institution, g				4b. City, Town, or		h		County of Death	
			Genesis Herit				Balti				altimo	
e.	Funeral Director		5. Social Security Number 6. 215-14-4821	Sex 1 □ M 2 □ F	Age (In yrs. Ia 81		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, Di Aug. 3	0, 19	9. Birth	place (State or Foreign ntry) Cork
	pu *		Usual Residence of Decedent  10a, State 10b, County		10c. City	Town or Lo	cation					10d. Inside City Limits
	sho ed al	5	MD Balti	more				altimor	e			1 ∑Yes 2 ☐ No
	28a-1	Funeral Director	10e, Street and Number				10f. Zip Code		7	10g. Citiz	zen of What Cou	ntry?
	3a or	₫	6114 Edmons	on Ave.			212	228		USA		
	death ms 2	Jera	11. Marital Status	12. Was Decede	nt Ever in U.S	6. 13. Y	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S	pecify Yes or N	0- 1	14. Race - Americ Black, White,	
36	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-1 show the Marical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ② Widowed 4 ☐ Divorced	1XXes 2	□ No		Yes 2 XNo	Specify:	to riloan, etc.,	1	Specify: Whi	
21215-0036	2 hou	ed	15, Decedent's	Education		16a. Deced	lent's Usual Occupa	ation	4.1-	16b. Kir	nd of Business/In	dustry
215	hin 7	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4)	or 5+)	life. L	kind of work done o	)	rking	TTC	D 6	NE 6 !
7	ar tha	9	12th			тес	ter Carı				Post C	orrice
Maryland	ba fila tal Hy d oth	Be	17. Father's Name (First, Middle, La					18. Mother's Na		, Maiden :	Sumame)	
<u> </u>	ould Men varka	ပ	Josef	Schloss	ser	405 14-105	g Address (Street		phine	or City or	Town State 7	- Code)
Nar	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship DorothyWillar		er		41 Lanso					(C00e)
e,	1 and Healt em 2 ther	-	20a. Method of Disposition	- daugni	20b, Pl	ace of Dispo	sition (Name of	T	Date		cation - City or To	own, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merial Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, It is Marical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		te HC	TyRe	deemer	2/5	/04	Bal	timore	MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lic	onsee Con	nell	.4	. Name and Addres	ss of Facility Co				eofEssex 21221
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	motications that cau	sed the death	Do not ent	er the mode of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	COX	DNAR	X AZ	ZTERY	PISEAS	E			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ence of):	. 0	,		_		
	Lxammer		Sequentially list conditions,	b. CEP	as a consequ	USS	repl BA	RC	DEN	7		
	led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	DIAR	ETE.		45/11-	TIOS				
	al-trai	Examiner	that initiated events resulting in death) Last	Due to (or	as a consequ	ence of):	1004	42	<u>.</u>			
8760,	death certificata be executed e attending physician and od for usa as the burial-transit	dicai E		d. MAL	XUT	TZ/;	16x					
.89	ificat g phy as the	edi								1		
Вох	eath certifi attending   I for usa as	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnar		Ectopic pregnancy			2	23d. Date of deliv	
	e deat he att	by Physician/Me	in the past 12 months? 1  Yes 2 No		t at time of de		Other (specify)				Month	Day Year
P.O.	that the ad by th detache	Phy	9 ☐ Unknown  Part II. Dther significant conditions	contributing to deat	h hut not reeu	Iting in the III	nderhing cause aw	an in Part I	23a Did	tobacco u	se contribute to t	he cause of death?
Division of Vital Records,	The law requires that the death certific ate has been signed by the attending to page 2 should be detached for use as	d by	Fait II. Ditief significant conditions	Contributing to deal	TI DUL TIOL TESU	atting in the di	Tide Hy and God Good Green			Yes 2		
OS	s baa	Completed							24a. Wa:	s an	24b. Were auto	opsy findings available ompletion of cause of
æ	Tha lav	E O							perf	omed?	death?	
ta		Be C	25. Was case referred to medical					26. Place of De	ath (Check only	one)	1	
<u>†</u>	Physician: r this certific ral director,	To	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	atient 2□I	ER/Outpatier	t 3 DOA Oth	er: 4 Nursing I	lome 5 🗆 Res	idence 6	S □Other (Specia	<b>(y</b> )
u o u	ng Pl		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of (Month,	njury Day Year)	28b. Time of Injury	Wor	k?	28d. Describe	how injury	y occurred	
sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	bo -	Jahren Akha			Yes 2 □No	29f Location	(Street and	d Number or Pur	al Route Number,
DΪΧ	il or Attend after death Director: A	Certification:	4  Homicide determine	ed 286. Place of building	, etc. (Specify	nie, iaim, sii	eet, factory, office		City or To	wn, State)	)	arriodie rumber,
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C		Physician: To the basiner: On the basiner and manne	s of examinat							
<b>)</b>	To the within To the compl	Me	29b. Signature and title of certifier	1/11	Mar. 1	10	29c. Licens	e number	2	29d. Date	e signed (Month,	Day, Year)
	5		30. Name and address of person w	to completed eatise	of death (Item	23a) (Type,	Print)	1120	on Nr	4	-5 2	1222
			31. Date filed (Month, Day, Year)		jistrar's Signal	14an	14-19	ice po	wallk	14	0 4	
	Sta Regist		FFB 0 6 200		w Sk	for	K)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** STENCEL MARY PATRICIA 04:12 AM February 04 /Medical 4e. Fecitity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HAR BOR HOSPITAL CENTER n/a 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 TF 218-22-6336 Director July 11 1932 Maryland Usual Residence of Decedent 10d. tnside City Limits 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at 1 Ves 2 No Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 E. Ostend Street 21230 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: à 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Bm 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Buck Glass 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Campbell Mary Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irvin P. Stencel (Son) 9 E. Ostend Street, Baltimore, Md. 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 02/07/04 Bayview Crematory \* 4 □Donation 15 □ Other (Specify) Baltimore, Md. 21. Signature of Fureral Sergice Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Conset and Death tmmediate Cause (Finat Physician HEPATIC 1 day FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Infarction ecardiat Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Encephalopathy be executed use as the burial-transit MetaBolic Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes ② No 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1½ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESODO 30. Name and address of person who completed cause of death (tiem 23a) (Type, Print) 160R DOROKHINE HospiTAL, 3001 South Hanover St., Baltimore, Maryland 32. Registrar's Sonature 31. Date fited (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 2004 2251 Marie Anna Sears 3 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Annapolis Anne Arunde1 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 73 Apr. 212-26-2429 1930 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show ral', or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Directo MD Anne Arundel Odenton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1110 Court Revere 21113 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo White "natural", or Specify. Specify. Ď 3XXWidowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene is marked other than Board of Education 10 Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Knoble Lillian Orick Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 : Department of Health ar important: If item 27 is sny injury or other trau Kevin Sears (Son) 1110 Court Revere, Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State St. Stephens Cem. 2/7/2004 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hardesty Funeral Home P.A. 21. Signatu of Funeral 12 Ridgely Avenue, Annapolis MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Inermoni /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ funeral director, page 2 should be 3 Probably 4 Unknown 1 Yes 2₽No Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 Yes 2 PNo 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA Certification: To 1 Tyes this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and proof certified 29c. License number MO 0 30. Name and address of pers no completed cause of death (Item 23a) (Type, Print) Times 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar EER 0 6 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:00 LEO ROBERT SCHWARTZ JAN 14 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 30, 1921 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours **X**□ M 2□ F 508-30-9985 82 Yrs Nebraska Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No VA Fairfax Fairfax Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 22032 10606 Henrico Street U.S.A. Неття 23а Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 14∑Yes 2 ☐ No 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Nerrany injury or other traumatic event, the Medical Education 1 Never Married 2 Married 1 ☐ Yes 💥 ☐ No White Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 Elementary/Secondary (0-12) College (1-4or 5+) Civil Servant Civil Service 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Francis J. Schwartz Mamie E. TePoel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9a. Informant's Name/Relationship (Type, Print) Christine Buchanan-daughter 10708 Howerton Ave, Fairfax, VA 22030 20b. Place of Disposition (Name of cametery, crematory or other place)
Arlington
National Cemeter Date 20c. Location - City or Town, Stete 20a. Method of Disposition

vE Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 2-12-04 Arlington, VA \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229 Yary Majwell 23a. Part1. Enter the disease or complications that caused the death. Shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY EDEMA Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran attending physician and Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊋Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No certificate has 1 Yes Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 XNo 1 🖁 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

P.O. Box 68760,

Division of Vital Records,

State Registrar

DAVID M. BRETT-MAJOR MC 31. Date filed (Month, Day, Year) 32 Registrar's Signature FEB 0 6 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



88648 (ME)

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

14, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Μ. SWINDER IRGINDA 4a. Facility Name (If not institution, give street and number) 4b. City. 7Kins onns Oita ( 104 TIMORE N/A If Under 24 Hrs. 5. Social Security Number 6. Sex In vrs. last birthday Birthplace (State or Foreign Country) Days Hours Months 1 ☐ M 2 🂢 F 214-20-0265 78 18 Jan. .1926 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Rosedale Maruland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 Elkhart Court 21237 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married ☐Yes 2 No 1 ☐ Yes 2 💢 No Specify: f Yes, Give Year or Dates: White Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12th Grade Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wisneiwski Stephen Anthony Beatrice Anna Szamski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Daniel Swinder 1115 River Road, Sykesville, MD (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem. 2/7/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service License 9705 Belair Rd., Baltimore, MD Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATORY Immediate Cause (Final INSUFFICTENCY 2 WEEK disease or condition resulting in death) ABDOMINA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

PLILMOWARY EMBOLUS 23e. Did tobacco use contribute to the cause of death? PULMONARY 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? 1X Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Examiner attending physician and for use as the burial-transit The law requires that the death certificate be execu Records, P.O. Box 68760, the ģ has certificate Division of Vital this After

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rai', or items 23a or 28e-f show Examiner must be notified at

"natural"

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permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra

Pnysician

/Medical

traumatic event, the Mudical

Director

Completed by Funeral

Be

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Physician/Medical Examiner þ Completed Be 7 Certification:

1 Yes 2 No

27. Manner of Death

1 X Natural

2 Accident

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

To the Hospital or Attending Physician: in by the funeral death. Director: within 24 hours after To the Funeral Direct

State Registrar

Medical

5 Pending investigation

6 ☐ Could not be

determined

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

3 DOA

- 000

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N. WOLFE ST. BALTIMOREMDALD

1 Inpatient

28a. Date of Injury (Month, Day Year)

			1 - For State Registrar	State of	f Maryla	nd / Depa <i>Cei</i>	artmen rtificat	t of F e of	lealth ar Death	nd Me	ental Hy	giene Reg. No.			05425
			1. Decedent's Name (First, Middle, La	,	• • •					:	2. Date of De			· · · · · · · · · · · · · · · · · · ·	3. Time of Death
	Physici /Medio		Susan Gertrude	. Simoe	5					F	EBRUA	Day BRY S		Year COU	12.01 AM
	Examir		4a. Facility Name (If not institution, gir	e street and nur	nber)		4b. City,	Town, o	Location of	Death		4c.	County o	f Death	
			GOOD SAMARI	TAN H	OSP IT	AL	BA	ALT	IHOR	E			N/I	A	
	Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs	. last birthday)	If Under Months	1 Year Days		Hrs. (	B. Date of Bi (Month, Da	rth		9. Birthpl	ace (State or Foreign
	Director		2.0 00 0002	1□M 2√F	67	Yrs.			1100.0		Sept.	24,1	936	Mar	yland
	pu *		Usual Residence of Decedent  10a. State 10b. County		100 0	ity, Town or Lo	cation							14	Od. Inside City Limits
	show	5	,		100.0	my, rown or co	Bali	t ima	- 0					1"	od. Inside City Limits 1 ☐ Yes 2 🌠 No
	Ne W	ecto		ne					ie						
	with t	늅	10e. Street and Number 3824 Proctor Lav				10f. Zip	Code	2123	21		10g. Citi:	zen of Wi		try?
	sath	Fra			alam Post Sale	10 40 1	**** 5							S.A.	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "netural", or Items 23e or 28e-f show event, the Mydical Exerciting at a vent, the Mydical Exerciting at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For 1 □ Yes If Yes, Giv Year or Da	rces? 2 🗶 No e	1:	was Deced fYes, sped I ☐ Yes	cify Cuba	ispanic Origir In, Mexican, F Specify:	n? (Spec Puerto Ri	ify Yes or No ican, etc.)			, White, e	
ŏ	2 ho	Completed	15. Decedent's E	ducation		16a. Deced	lent's Usua	al Occup	ation			16b. Kir	nd of Bus	iness/Ind	ustry
2	- 35	Be	(Specify only highest gr Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	KIND OF WO DO NOT U	rk done d se retired	during most o	t working	7	Loy	ola (	Colle	ege
21	filed with Hygiene. Ither ther	PO		2	10.0.7	Execu	tive	Assi	istant			Grad	duat	e Di	vision
ğ	e filed al Hygi other vent, I	Be	17. Father's Name (First, Middle, Las								First, Middle			,	
<u>a</u>	should be filed within and Mental Hygiene. marked other then metic event, the M	5	Paul Wilson Do	ve					Marga	ret	Eliza	beth	Rau	usch	
a	2 should be fi and Mental F Is marked ot eumatic ever		19a. Informant's Name/Relationship		_	1			and Number					tate, Zip	Code)
Σ	1 and 2 Health tem 27		Mr. Thomas F. Sin	ioes (hu					Lane,	Bal	timore	, MD	21:	236	
Ž	es 1 ar of Hea of Hear fitern		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 [	Demoual Iron (	20b.	Place of Dispo- cemetery, cren	sition (Nar.	ne of ther plac	e)	Da	te	20c. Lo	cation - C	ity or To	<b>v</b> ⊓, State
Ĕ	Pages nent of B ent: If its ury or of		`4 □Donation 5 □ Other (Speci			. Josep				17/20	004	Ful	lert	on, N	<i>laryland</i>
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any injury or other treumatic 2008.		21. Signature of Funeral Service Lice	ns@e		22	. Name an	d Addres	s ol Facility	Sch	imunek	Func	eral	Home	2.5
Φ	g g € ≅ g		Tomo I	Her .	1				ir Rd.					21236	
68760,	Physician bhysician and bhysician and physician and street	ai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. SEPSIS  Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d												Interval Between Onset and Death
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P.O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		rth 2 ☐ Fet ant at time of	al death 3 🗌	Ectopic pr Other <i>(sp</i>					2	3d. Date Monti		y Day Year
	that sed b		Part II. Other significant conditions	contributing to de	ath but not re	sulting in the un	derlying c	ause give	n in Part I.		23e. Did t	obacco us	se contrib	ute to the	cause of death?
ġ	uires a sign lid be	Completed by	KLATSKIN TU	MOR							10	Yes 2	No 3	☐ Proba	bly 4 ⊠Unknown
8	w require been si should I	ete									24a. Was	20	24b W	ara autan	sy findings available
æ	The lay	E					_				autop		pri	or to com ath?	pletion of cause of
B	n: T ficate or, pa		OF Miss ones released to madical									2 KNo	1 [	Yes 2	2Ø No
⋚	Physicien: r this certifica ral director, p	Be C	25. Was case referred to medical examiner?	Hospital:		7.50	-57	Othe	100		Check only o				-
ot	Phys rthis ral di	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o		ER/Outpatient 28b. Time of		A	4 🗀 Nursii		5 Residue 1				
on	ding th. After funer	ţi	1 Natural 5 Pending 2 Accident investigatio	(Monti	n, Day Year)	Injury	м	8c. Injury Work 1 □ Y	:? ∕es 2 ⊡No	1			000000	•	
Division of Vital Records,	ne Hospitel or Attending P n 24 hours after death. he Funerel Director: After t bletely filled in by the funera	Certification:	3 Suicide 6 Could not be determined	e 28e. Place	of Injury - At h g, etc. (Speci	nome, larm, stre	eet, lactory				Location (S City or Tox		Number	or Rural	Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical (	29a. Certifier 1-2 Certifying Pl (Check only one) 2 Medical Exam	nysician: To the miner: On the ba and mann	sis of examin.	owledge, death ation and/or inv	occurred estigation,	at the tim in my op	e, date and p inion, death o	olace, and	d due to the at the time,	cause(s) a date and p	and manr place, an	ner as sta d due to t	ted. the cause(s)
	To the I within 2. To the I complet	Σ	29b. Signature and title of certifier	<u>.</u>			29c	. License	number			29d. Date	signed (	Month, D	ay, Year)
	~/		RNOCOnha	M.7	١.		K	RES	00		1	FEBR	JAR	1 5	2004
	1 hX		30. Name and address of person who	completed cause	of death (Ite										
_				HA 56	01 60	GH RI	HUEW	Bi	-VD /	BAN	-TrHO	PRE	M	0	21239
	Sta Registr	- 1	ROHINI NORGW 31. Date liled (Month, Day, Year)	3.0 R 32 R	gistrar's Sign	ature	K	Local	7						

SUSAN

State of Maryland / Department of Health and Mental Hygiene For State Registra MFND ITEM #1 PER PHY G828 2/06/04 Mertificate of Death ALPHA MAE INGRAM SPRIGGS 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 121445 10:10 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Eldercare @ Franklin Woods Baltimore
If Under 1 Year | If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year May 10, 19 Birthplace (State or Foreign Country) 5. Social Security Number 23334843 7. Age (In yrs. last birthday) 6. Sex Days **Funeral** Hours 1 ■ M 2 XF Months Min. 78 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show Examiner niest be notified at 1 ☐ Yes 2X No Directo Harford Maryland Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3003 Woods End Drive 21085 USA or Iteme 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2000 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify ð 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Mudical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) rthan Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11 Own Home 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit iment of Health and Mental H tant: If Item 27 Is marked off Be Henry Dewey Lilly Mae Melvin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3003 Woods End Drive, Joppa, Maryland 21085 of Disposition (Name of Date 20c. Location - City or Town, Stat Marvin W. Spriggs / Husband other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or Holly Hill Memorial Pk. 2-7-04 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between PNEUMONIA Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): COBACTERIUM AVIUM COMPLEX **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ó in the past 12 months? Month Day Year signed by the at d be detached fo 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown peen PAN CHEATE CTOM 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Solursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA hours after death. Inerel Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d, Date signed (Month, Day, Year) 29b. Signature title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 30 BSni We Dr. Gran ELIASSON

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 0 6 2004

**ORIGINAL** 

₿2. Registrar's Signature

			1 - For State Registrar	State of Marylan		nent of F		Re	g. No.	001:27
	Physici	an	1. Decedent's Name (First, Middle, Last)  JEANETTA THE	CKER				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give s		4b.	City. Town. o	r Location of Dea	FEBRUARY	4c. County of Dea	
	CXAIIII	lei	UNIVERSITY OF MARY				MORE		NA	
	uneral irector		5. Social Security Number 6. Sex 219-66-8010	7. Age (In yrs. )		nder 1 Year oths Days	if Under 24 Hr Hours Mir		9 Bir	thplace (State or Foreign puntry) MD
/land	MO II		10a. State 10b. County	10c. City	y, Town or Location	1				10d. Inside City Limits
Man	all all all all all all all all all all	tor	MD NA		BALT	IMORE				1 X Yes 2 □ No
ith the	or 28	Oire	10e. Street and Number			f. Zip Code		10	g. Citizen of What Co	ountry?
ath w	8 23a	rai	1517 N. CAROLIN				21213		U.S	
fter de	r Item	Funeral Director	11. Marital Status  1 Never Married 2 Married	<ol> <li>Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes 2 ☒ No</li> </ol>			ispanic Origin? ( in, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
ours a	e Evan	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 🗆 Y	es 2 No	Specify:		Specify.	'RICAN IERICAN
filed within 72 hours after death with the Maryland	dical	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's (Give kind o	f work done	during most of we	orking 16	6b. Kind of Business	Industry
within	than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		OT use retired NURSIN			NURSING	
		Be Co	17. Father's Name (First, Middle, Last)	ı		NULCHION		ame (First, Middle, Ma	AGENCY aiden Sumame)	
should be		To B	WADE FOWLKES				DOR	A KNIGHT		
2 sho	Is m		19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mailing Add	ress (Street		Rural Route Number, (	City or Town, State, 2	Zip Code)
1 and 1	her tr		HOWARD THACKER	(HUSBAND)	1517 N. lace of Disposition		LINE STR		IMORE, MD	21213
	Important: If itam any injury or othe once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Re	0/	emetery, crematory	or other plac		16	c. Location - City or	Town, State
permit. Pages	ortant injury		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	MT.		CEMETE e and Addres		A THE RESERVE THE PARTY OF THE	LANSDOWNE,	
	any ir		Trylan / / /h	/			4.5	YLIE FUNER EET BALTI		A 21217
/M	sician ledical		23a. Fart1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	eations that caused the death e cause on each line. Colde Est	Do not enter the	mode of dyin	g, such as cardia	ac or respiratory arres	t,	Approximate Interval Between Onset and Death
22	hysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
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law requires that	been signed I should be det	by	Part II. Other significant conditions cont	ributing to death but not resu	lting in the underlyi	ng cause give	en in Part I.	I	cco use contribute to	the cause of death?
The	ate has page 2	Completed						24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
Physician:	certificate irector, pag	Be	25. Was case referred to medical examiner?					ath (Check only one)		
. &	SIC	. To	1 ☐ Yes 2 No Ho  27. Manner of Death		P/Outpatient 3	DOA Othe	4 Nursing I	Home 5 Residence		rify)
ding	After	tion	1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ? ∕es 2 □ No	28d. Describe how	injury occurred	
al or Attending s after death.	To the Funeral Director: After the completely filled in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, fac		2	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
he Hospit	the Funera	edicai	one)	cian: To the best of my knower: On the basis of examinati and manner stated.	vledge, death occur on and/or investiga	red at the tim tion, in my op	e, date and place inion, death occi	e, and due to the caus urred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
Tot	To t	Ž	29b. Signature and title of certifier	C. H.	().	29c. License			Date signed (Month	
			> Sichihah	- //	en	151	5+	i.E	REPUREY	3,2004
			30. Name and address of person who com			1-kl 4	And in the	Ruly and to a sound	2 - 2 may 12 day 14	AND SIDES
1	Sta	e	SIDDIHARNIH THA  31. Date filed (Month, Day, Year)	32. Registrar's Signato	ure	PMC 3	111661	MITIPUR	L, rameye	17ND 2061
	Registra		EED 0 6 20	. /	e la	A com	cut 1 -			

			For State State Registrar	ate of Maryland		tment of H ificate of			iene	)4	034.3
			Decedent's Name (First, Middle, Last)		_			2. Date of Deat	h		3. Time of Death
	Physicia /Medic		Joseph James I	Votava, Jr	•			Februar	Day LY 2. 21	9 0 4	1:20 P M
	Examin		4a. Facility Name (If not institution, give street			4b. City, Town, o	or Location of Death		4c. County	of Death	
			Heritage Nursing Co				ndalk	1		ltimo	
	Funeral Director		5. Social Security Number 6. Sex 150 M 2	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 29,	Year) 1925	9. Birthr Cour Ma	place (State or Foreign ntry) VLYLAND
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loca	ation		<del></del>		1	10d. Inside City Limits
	Many feho	ō	Maryland Baltin	no h o			N/A				1 ☐ Yes 2 No
	r 28a	rec	10e. Street and Number	iorce _		10f. Zip Code	- N/ F	1	0g. Citizen of V	Vhat Cour	ntry?
	h with	2	1005 Debbie Avenue				21221		u.	S. A	١.
	ems a	Funeral Director	11. Marital Status 12. W	as Decedent Ever in U.S med Forces?	S. 13. W		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race		can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating must be rediffed at once.	by Fu	1 Never Married 2 Married 1	()Yes 2 □ No Yes, Give		JYes 2∭ No			Specify		ite
우	tural	edt	15. Decedent's Education	ear or Dates:	16a, Decede	nt's Usual Occur	pation		16b. Kind of Bu		
215	nin 72 na "na Media	Pet	(Specify only highest grade com	oleted)	(Give ki	nd of work done NOT use retire	oation during most of works d)	ing			Back River
212	d with giene grene	Completed	10th Grade	mege (1940) 34)	Car	Repair	man			ilro	
P	be file	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name			θ)	
yla	should bend Ment	ဥ	Joseph J. Votava, Si				1	illian F			
Jar	l 2 sh and r Is m		19a. Informant's Name/Relationship (Type, Pr	int)			and Number or Rura				
, e	1 and 2 Health a em 27 is ther trau	1	Marian Votava (Wife) 20a. Method of Disposition	20b. Pla	1005 Lace of Disposi	OD (Name of	venue, Ba	etimore,	Maryka 20c. Location -	ind 2	1221
ō	ages nt of t: If it		1 Ø Burial 2 ☐ Cremation 3 ☐ Remov	al from State ce	metery, crema	tory or other plac	ce)				
Baltimore, Maryland 21215-0036	artme ortani Injury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Dicensee	Bun		National Name and Addre		1004   1 himunek			Maryland
ã	permit. Departr Importa any Inja		> Will Doel	ands	33	31 Breh	ms Lane,	Baltimor	e, Mari		
			23a. Part. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. se on each line.	. Do not enter	the mode of dyir	ng, such as cardiac o	or respiratory arre	est,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	10-	0 - 3	101 11	_		
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W-	execu n and ial-tra	Examiner	that initiated events c resulting in death) Last	Due to (or as a conseque	ence of):					-	
68760,	cate be executed physician and the burial-transit	edical	<b>L</b> d								
_		Med	IF FEMALE:								
õ	ath ce ttendi or use	an/I	23b. Was decedent pregnant 12 months?	res, outcome of pregnan ☐Live birth 2☐Fetal	death 3 □E	ctopic pregnancy	,		23d. Date Mor	of delive	ery Day Year
Division of Vital Records, P.O. Box	uires that the death certific signed by the attending p d be detached for use as	Physician/M	1 Voc 2 DNo 4L	Pregnant at time of dea Unknown	ath 5□(	Other (specify) _			10.01		ouy rour
σ.	that the ned by detail	by Ph	Part II. Other significant conditions contributi	ng to death but not resul	Iting in the und	erlying cause giv	en in Part I.	23e. Did tob	acco use contr	bute to th	ne cause of death?
rds	w requires been sign should be	ed b						1 □ Ye	s 2□No	3 🗌 Prob	ably 4 Dunknown
ဝ၁	law requ as been 2 shoulk	Completed						24a. Was ar	24b. V	Vere autor	psy findings available inpletion of cause of
Œ.	iiclan: The lav certificate has rector, page 2	Сош						perform	ied? d	eath?	2 No
/ita	iclan: sertific ector,	Be	25. Was case referred to medical examiner?	d.		104	26. Place of Death	(Check only one	9)		
of	Phys this al dir	٦.	1 ☐ Yes 2 ☑ No Hospita 27. Manner of Death 28a	1 Inpatient 2 E	R/Outpatient 28b. Time of	3 DOA Oth	4 Mursing Hor	ne 5 Reside 28d. Describe ho			/)
on	ding th. After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injur Wor M 1 🗆	k? Yes 2 □ No	Edd. Describe 110	w injury occurre	,	
<u>Visi</u>	Atten r dea ector by the	Certification:	2 Suiside 6 Could not be	Place of Injury - At home building, etc. (Specify)	ne, farm, stree	t, factory, office		28f. Location (Str City or Town	eet and Numbe	er or Rura	l Route Number,
۵	Ital or rs afte ral Dir led in	Cert									
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be delached for use a	Medical	(Check only 2 Medical Examiner: O	To the best of my know in the basis of examination and manner stated.	rledge, death o on and/or inve	ccurred at the tir stigation, in my o	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	use(s) and mar te and place, a	nner as st nd due to	ated. the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed	(Month, I	Day, Year)
	M		Sounder 16	Kege 1	10	02	7198		2/4/0	X	
1	W		30. Name and address of person who complete	ed cause of death (Item	23a) (Type, Pr	int) / S	1	). 1	0- 1	. 3	2/277
	8		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	Model	2 //	40	(Metter	16 14	0 -	2/222
	Sta Registr		FEB 0	6 2004	Esser 1	1 Soo	le				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			For State Of Maryland  1 - State Registrar	Certificate of Death	Reg.	200 00 00 1 00 00 1 1 10 10 10 10 10 10 1
	Physicia /Medic		Decedent's Name (First, Middle, Last)     Mary M. Whitty		2. Date of Death Month Fe h 2,	Day Year 6.15 p. M
2	Examin		4a. Facility Name (If not institution, give street and number) St. Elizabeths Home	4b. City, Town, or Location of Baltimore Ci	ty	4c. County of Deeth N/A
	Funeral Director		5. Social Security Number 216-10-7704 6. Sex 1 □ M 25€ 7. Age (In yrs. last 93	t birthday) If Under 1 Year If Under 2 Yrs. Months Days Hours	Min. 8. Date of Birth (Month, Day, Ye January 18,	ar) 1911 9. Birthplace (State or Foreign Country) MD
	Maryland	tor	Usuat Residence of Decedent  10a. State 10b. County 10c. City, 1  MD 1/A	Fown or Location Paltimore		10d. Inside City Limits ▼23Yes 2 □ No
	h with the 23a or 28a	al Director	10e. Street and Number 1442 Cooksie Street	10f. Zip Code 21230	10g.	Citizen of What Country?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tiern 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exacilizar must be notified at angles.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes <b>2XX</b> No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
215-0	nin 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	<ol> <li>Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)</li> </ol>	of working	o, Kind of Business/Industry
d 21	filed witi Hygiene ther tha int, II.	Com	8 0	Icomaker 18. Mother	r's Name (First, Middle, Maid	Manufacturing  den Sumame)
ylan	ould be Mental Arked o	To Be	John Washburn		garet V. McGee	
Mar	nd 2 sh alth and 27 is m or traum		19a. Informant's Name/Relationship (Type, Print) Carolyn J. Hood/Cousin	19b. Mailing Address (Street and Number 7 Griffin Ct., New Free		ty or lown, State, Zip Code)
Baltimore, Maryland 21215-0036	Pages 1 a nent of He ant: If item ary or othe		cem	e of Disposition (Name of teletry, crematory or other place)  Cross Cemetery February		altimore Maryland
Balti	permit. Departr Importa any inje		21. Signature of Funeral Service Licensee Victor P. Doda,	Jr. 22. Name and Address of Facility Charles L. Stevens 1501 Fast Fort Aven	Funeral Home, Ir.	rc. 0.21230
2	Physician /Medical		resulting in death)	cardiac or respiratory arrest,	Approximate Interval Between	
**	Examiner		Due to (or as a consequen		,.	
	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nce of):		
68760,	ificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last  Due to (or as a consequent d.			
P.O. Box 68	death cert e attendin ed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal di 4 ☐ Pregnant at time of deal	eath 3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
	8 5 9 P	b	Part II. Other significant conditions contributing to death but not resulting	ing in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Records,	e law has t	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  17 10 17 11 11 11 11 11 11 11 11 11 11 11 11
of Vital	sician: certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 100 Hospital: 1 Inpatient 2 E		of Death (Check only one)	a & DOther (Specific)
	ng Phys fter this ineral di	on: To	- 3	8b. Time of 28c. Injury at Work?	28d. Describe how	
Division	If or Attending after death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	M 1 ☐ Yes 2 ☐ Nie, farm, street, factory, office		at and Number or Rural Route Number, State)
X	Hospita 4 hours Funerel Bly filled	edicai Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowl 2 Medical Examiner: On the basis of examination and manner stated.			
	To the h within 24 To the f complete	Me	29b. Signature and title of certifier / M	29c. License number	76 F	Date signed (Month, Day, Year)  Br., 4,2004  Lt un 21228
	4				lare la	et un uns
*	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  FFB 0 6 2004  32. Registrar's Signatu	" Amelle		

			1 - For State Registrar	State of Maryla	nd / Dep		lealth and			(J.,.j()
Ŷĸ	Physici		1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year 26, 2004	3. Time of Death 2:20 PM M
	/Medic Examin		Shirley Mae Way: 4a. Fecility Name (If not institution, give			4b. City, Town, o	r Location of De		4c. County of Deat	
			1224 Cathedral I			Glen H			Anne Arı	
	Funeral Director		215-24-8516	9X □ M 2X F 7. Age (In yrs	. last birthday, Yrs.	Months Days	If Under 24 H Hours M	in (Month, Day, )	9. Birt 1929 Man	nplace (State or Foreign untry) cyland
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
	a-f sho	ctor	MD Anne Ar	ındel	G	len Burni	Le			1 ☐ Yes 2X No
	death with the Maryland ms 23a or 28a-f show r must be maiffied at	Funeral Director	10e. Street and Number 1224 Cathedral D	rive		10f. Zip Code	21061	10	g. Citizen of What Co USA	untry?
	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural; or liems 23a or 28a-1 show event, the Medical Exam as must be multiled at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Moivorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	s filed within 72 hor I Hygiene. other than "naturi ent, the Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of v	vorking	6b. Kind of Business/	industry unk
	lled wi tygien her th		12	0	5	secretary	19 Mather's h	lame (First, Middle, Ma	aidan Cumama)	
and		o Be	17. Father's Name (First, Middle, Last)  John Henry	Wayson				ence Ceceli		
Maryiand	s 1 and 2 should be if Health and Mental litem 27 is marked o other traumatic eve	To	19a. Informant's Name/Relationship ( Hospice of the		19b. Maili	ng Address (Street		Rural Route Number,		ip Code) unk
Baltimore,	e = 5		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specification)	Removal from State	Place of Dispo cemetery, cre	osition (Name of matory or other plac	Ce)	Date 20	Oc. Location - City or	Fown, State
Бап	permit. Pag Department Important: any injury once.		21. Signature of Euneral Service Licer		r s	2. Name and Addre tate Anat dittimore,	ss of Facility Omy Bya	561655 W. 1	Baltimore	Street
	Physician /Medical Examiner		23a. Part 1. Enter the disease, at consolid control co	blications the caused the deaper cause on each line.  a. Carcino M  Due to (or as a conse					it,	Approximate Interval Between Onset and Death
, 00,	e be executed sician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.)					77	
ň	nt the death certificate by the attending phys lached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3[	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of deli Month	very Day Year
ds, r	uires tha signed d be de	d by Pt	Part II. Other significant conditions of	ontributing to death but not re		-	en in Part I.	- 1	cco use contribute to	the cause of death?
Hec	The law ate has b page 2 sl	Completed						24a. Was an autopsy perform	prior to death?	topsy findings available ompletion of cause of
VItal	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	nt 3□ DOA Oth	or	eath (Check only one) Home 5 - Residen	ce 6 Sother (Spec	ASSISTED
on or	ding Phys h. After this funeral di	<del> </del>	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur		28d. Describe how		"YLIUING
DIVISION	he Hospital or Attanding Ph in 24 hours after death. he Funeral Diractor: After th pletely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		nome, farm, st	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or I within 24 hours after To the Funeral Dirac completely filled in b	Medical (	29a. Certifier 1 Cartifying Ph (Check only 2 Medicel Exemone)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deat ation and/or in	th occurred at the tire	ne, date and pla pinion, death oc	ce, and due to the cau	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of continer	10		29c. Licens		290	d. Date signed (Month	, Day, Year)
			1 / Mu		m 23a) /T:	1	583 6 CR	AIN HU	30/21	204
			30. Name and address of person who ANA STACIO	E, SUBO	NGIZ			BURN		21062
150	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sign	K A	sales)				

Completed by Funeral Director	10e. Street and Number 9004 Manchest 11. Marital Status 1\(\time\) Never Married 2 \( \time\) Ma 3 \( \time\) Widowed 4 \( \time\) Divorce 15. Decede	mberly  on, give street and numb.  Hospital  6. Sex 1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M	Age (In yrs.  10c. Ci  int Ever in U	last birthday) Yrs.  ity, Town or Lo Silver	ocation Sprin	er Sp Year I Days	oring fUnder 24 Hours	Hrs.	2. Date of Dea Januar Januar 8. Date of Birt (Month, Da) Jan 24	y 24, 4c. Cour Mon	9. Birth Cou	ry
xaminer neral ector	Holy Cross  5. Social Security Number none  Usual Residence of Decedent  10a. State 10b. Count  MD Mont  10e. Street and Number  9004 Manchest  11. Marital Status    Never Married 2   Marchest   Marital Status   Marchest	Hospital  6. Sex 1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  7.  1 M 2 F  1 M 2	Age (In yrs.  10c. Ci  int Ever in U	Yrs. ity, Town or Lo Silver	Silve  If Under 1  Months  Cocation  Sprin	er Sp Year I Days	oring fUnder 24 Hours	Hrs.	8. Date of Birth (Month, Day Jan 24	Mon h, Year)	9. Birth Cou Mar	ry place (State or Foreign ntry) yland
tor	none  Usual Residence of Decedent  10a. State  10b. Count  MD  Mont  10e. Street and Number  9004 Manchest  11. Marital Status  MNONE  15. Decede  (Specify only high  Elementary/Secondary (0-12)  none	gomery  er Road #24  12. Was Decede Armed Force 1   Yes, Give Yes, Give Yes ar or Date  ont's Education est grade completed)  College (1-44)	10c. Ci	Yrs. ity, Town or Lo Silver	Months  Docation  Sprin  10f. Zip C	Days 1g	Hours	Vin.	8. Date of Birth (Month, Day Jan 24	h y, Year) , 2004	Mar	yland
1 1	10a. State MD  10b. Count Mont  10e. Street and Number  9004 Manchest  11. Marital Status  11. Never Married 2 Ma  3 Widowed 4 Divorce  15. Decede  (Specify only high  Elementary/Secondary (0-12)  none	gomery  er Road #24  12. Was Decede Armed Force 1   Yes   2   1/ Yes, Give Year or Date  work's Education est grade completed)  College (1-44)	ent Ever in U	Silver	Sprin	ode						10d. Inside City Limits
Completed by	9004 Mancheste  11. Marital Status    Never Married 2   Ma 3   Widowed 4   Divorce  (Specify only high  Elementary/Secondary (0-12) none	12. Was Decede Armed Force 1   Yes 2   If Yes, Give year or Date ont's Education est grade completed)  College (1-4e)	es? ∑No	J.S. 13. \								1 ☐ Yes 27 No
e Completed by Funeral	11. Marital Status  1\( \text{\text{Never Married}}  2 \cup Ma \)  3  \text{Widowed}  4  \text{Divorce} \)  15. Decede (Specify only high Elementary/Secondary (0-12) \)  17. The status is the status of the	12. Was Decede Armed Force 1   Yes 2   If Yes, Give year or Date ont's Education est grade completed)  College (1-4e)	es? ∑No	J.S. 13.		')(	0901			10g. Citizen o		ntry?
le Completed	(Specify only high Elementary/Secondary (0-12) none	est grade completed)  College (1-4e			Was Decede If Yes, specif 1 ☐ Yes 2	nt of Hisp y Cuban,		? (Spec	cify Yes or No- lican, etc.)	14. R	USA ace - Americack, White,	
; ;		none	or 5+)	(Give	dent's Usual kind of work DO NOT use none	done duri		workin	g	16b. Kind of	Business/In	dustry
To B						nk 18			(First, Middle, Wimber	Maiden Sumi	зте)	
	19a. Informant's Name/Relation Holy Cross Ho			19b. Mailin 1500	ng Address (S Fores	Street and st G1	Numbero Len Ro	r <i>R</i> ural 1 Si	Route Number 1ver Sp	r, City or Tow pring,	n, State, Zip MD 2	20901
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 💆 Other (		ate of	Place of Dispo cemetery, crem	sition (Name natory or oth	of er place)		Da	110	20c. Location	n - City or To	own, State
	21. Signature of Funeral Service ROTIA LO	S. Wade Di	recto	r St	Name and Late And Lltimon	Address on a ton	of Facility Boa	ard 201	655 W.	Balti	more S	Street
	23a. ant1. Enter the diseas for heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	acare Due to (or	dio re asaconseo reme p	espirat quence of): prematu	ory fa			diac or	respiratory arr	rest,		Approximate Interval Between Onset and Death
dicai Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. cho:	as a consec rio an as a consec	nnionit	is mat	erna	1					
/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	2 ☐ Feta t at time of o	al death 3 🗆	Ectopic preg Other (spec						ate of delive	ary Day Year
ed by P	Part II. Other significant condit	ions contributing to death	h but not res	sulting in the ur	nderlying cau	ise given i	n Part I.	_	23e. Did to			ne cause of death?
Completed		<u>-</u>						- '	24a. Was a autops perform	SV	. Were auto prior to con death?	psy findings available mpletion of cause of 22 No
	25. Was case referred to medic examiner?  1  Yes 2 No	Hospital: > /	atient 2 🗆	] ER/Outpatien	t 3 DOA	Other			Check only on		ther (Specifi	V)
Certification:	Z - risoldolii	tigation	njury Day Year)	28b. Time of Injury	280 M	injury at Work? 1 ☐ Yes	2 □ No	28	d. Describe ho	ow injury occu	irred	
	4   Homicide	mined 288. Place of building,	etc. (Specif					-	City or Town	n, State)		il Route Number,
Medical	(Check only 2 Medica	ing Physician: To the be I Examiner: On the basis and manner	s of examina	owledge, death ation and/or inv	occurred at restigation, in	the time, my opini	date and poon, death o	ace, ar	d due to the cad at the time, d	ause(s) and n ate and place	anner as st , and due to	ated. the cause(s)
	29b. Signature and title of certification	Duenz	- DR	CAD	1	+ O	045	95	2 2	9d. Date sign		Day, Year)
	30. Name and addless of person  10 Corol  31. Date filed (Month) Day, Yea.	Douris	of death (Item	n 23a) (Type, I	1 - 1	1 Select	2201)	It	osp.the	- ,	1.V)	

		For Amend Items#10e State 19a,b,20a,b.	State of N 2, f, 11, 15, 16a 3, c, 21, 22	laryland /	Depa Cer	artment of tificate of	Health and Death	Mental Hy	giene 2	004	3. Time of Death
Physicia /Medica	ın	Gertrude Will						Janua	Day	2004	634AM
Examine	er	4e. Fecility Name (If not institution,	give street and number	1 1	0	D . 1.	or Location of De			nty of Deeth	
Funeral		Maryland G 5. Social Security Number 6	eneral 7. A	H6SDIT	U J	If Under 1 Year		rs. 8. Date of Bir	th	9. Birthp	elece (Stete or Foreign
Director		219-70-5924	1□M 2ÅF	81	Yrs.	Months Days	Hours M	s. Date of Bir (Month, De Oct 7,	1922	SOUIH (	Carolina
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation				1	0d. Inside City Limits
e Mary a-f eh	cto	MD		Ва	altim	ore					1X Yes 2 □ No
ide 66 after death with the Maryland or litems 23a or 28a-f show priner must be notified at	Director		Gertrude ST			10f. Zip Code	21216		10g. Citizen	of What Coun	ntry?
Seath v seath v must	ē	11. Marital Status	n Street 12. Was Deceden	t Ever in U.S.	13. V		201 Hispanic Origin?	(Specify Yes or No	US.	A Race - Americ	an Indian,
ULC 336 urs after aft., or its	É	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	No Table	<del>-</del>	Yes, specify Cub		(Specify Yes or No erto Rican, etc.)	Spe	Black, White, cify: b	etc. 1ack
/ - c * M	Completed	15. Decedent's (Specify only highest		16	(Give	lent's Usual Occu kind of work done DO NOT use retire	during most of v	vorking — unle	16b. Kind of	Business/Ind	dustry <del>unk</del>
2121 2121 od within ogiene.		Elementary/Secondary (0-12)  unk 10	College (1-4or		mestic		9Q)		Privat	e	
land lind lind lind lind lind lind lind li	To Be C	17. Father's Name (First, Middle, La Weston Gibson	rst)			<del>-unk</del>	- 18. Mother's N Jane N	lame (First, Middle, fireni			unk
and and		19a. Informant's Name/Relationship M's Hattie Rhames Maryland Genera	o (Type, Print) S. (Niece) 1 Hospital	1	9b. Mailin	Address (Stree	tand Number or e St Lalto venue sa	Rural Route Number Md 21216		vn, Stete, Zip	Code)
0 00-		20a. Method of Disposition 1	city) in stat	Mt Ca	mel	sition (Name of natory or other pla	3/1/	Date 12004	Dunda1	•	wn, State
Baltimol Baltimol permit. Pages Department of important: If it		31- Signature of Funeral Scyce Lin	censee Joseph	Russ per	120	Name and Addr	COMP DOGE	seph I. Ruse 201—2222 V		100 A 100 A	to Md 21216
3451	1	23a Pert1. Enter the disease, or cl shock, or heart failure. List or	omplications that cause nly one cause on each	d the death. D	o not ente	1		iac or respiratory a	rest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Athero	scler	otic	card	iovascu	elar I	Di Sea	se	Onsor and Dount
Examiner		Consensation the tips and distance	Hyper	tens	100						
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3760, ate be executed systcien and he burial-transit	ical Examiner	that initiated events resulting in death) Last	cDue to (or as	s a consequenc	ce of):						
687 tificate tig phys	ledic		d								
Vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be execular death.  •ctor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-trans.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		e of pregnancy 2 Petal dea at time of death		Ectopic pregnand Other (specify)	Ey .		Į.	Date of delive Month	ry Day Year
IS, P.O.	y Ph	Part II. Other significant condition	s contributing to death	but not resulting	g in the un	derlying cause gr	ven in Part I.	23e. Did to	obacco use co	ontribute to th	e cause of death?
cords,	ed b							101	res 2□No	3 Proba	ably 4 Donknown
Division of Vital Records, to attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed							24a. Was autop perfo	rmed?	o. Were autor prior to con death? 1 \(\sum \) Yes	osy findings available npletion of cause of
Vital Fidina Thirdina The Certificate	Be	25. Was case referred to medical examiner?	. Hanning .	- /				eath (Check only o			
on of Vital Reling Physician: The Learning Physician: The Learning Physician The Luneral director, page	٠. To	1 Yes 2 No  27. Manney of Death	Hospital: 1 ☐ Inpat	17.0	Outpatient	30 0011		Home 5 ☐ Resid			"
ision ( ttending F death. ctor: After y the funer.	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Inj (Month, Date)	ay Year)	Injury	28c. Inju Wo M 1	rk? ]Yes 2∐No		ion injury odd	31100	
	Certification:	3 Suicide 6 Could no 4 Homicide determine	ad 280. Place of in	ntury - At home, tc. (Specify)	farm, stre	eet, factory, office		28f. Location (S City or Tox		nber or Rurai	l Route Number,
Divisit  To the Hospital or Attention within 24 hours after deatt  To the Funeral Director: completely filled in by the	Medical	one) 2 Medicel Ex	Physician: To the best caminer: On the basis of and manner s	of examination :	lge, death and/or inv	estigation, in my	opinion, death oc	ce, and due to the curred at the time,	cause(s) and date and place	manner as sta e, and due to	ated. the cause(s)
To I with To under the common	2	29b. Signature and title of certifier	10 yours			29c. Licen	to 8		29d. Date sign	8 64	Day, Year)
		30. Name and address of person with School Uous	no completed cause of	death (Item 23a	a) (Type, i		nd d	sereral	H	sspit	a
Stat		31. Date filed (Month, Day, Year)	32. Regist	trar's Signature						1	
Registra	9	FEB 0 6 2004	Benev	a B	A	souls					

# 1\_ For State Physician /Medica Examine **Funeral Director** permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Modical Examinar must be notified at once.

TOD 10:30 PM

DOD 1-28-04

ANNE B.

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar			CE	uncate	OI D	eaui			Reg. N	No.	
1. Decedent's Name (First, Middle, La	st)							2. Date of De		Day Year	3. Time of Death
E	Anne B	White						Januar		28, 2004	10:30P M
4a. Fecility Name (If not institution, giv	e street and nu	mber)		4b. City, To	own, or L	ocation (	of Death		4	c. County of Deeth	1
Manor Care Potoma	ac			Pe	otom	ac			M	lontgomer	v
5. Social Security Number 6. S	Sex	7. Age (In yrs. last	birthday)	If Under 1		If Under		8. Date of Bir	th	9. Birth	place (State or Foreign
180-30-2606 Usuel Residence of Decedent	I□M 2ሺF	71	Yrs.	Months	Days	Hours	Min.	Jan. 3			nsylvania
10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits
Florida		A+1.	ntio	e Beacl	h						1 ☐ Yes 2 X No
10e. Street and Number		ALIA	111 6 1 6	10f. Zip C					10a C	Citizen of What Cou	into/?
	. 1								_		•
1729 Seminole Roa	T	edent Ever in U.S.	12		2233	ania Ori	nin2 /Cn/	noity Von or No		ted Stat	
11. Marital Status  1 Never Married 2 Married	Armed Fo	rces?	10.	If Yes, specify	y Cuban,	Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	,-	Black, White	
3 Widowed 4 Divorced	If Yes, Gr	/8 11		1 ☐ Yes 2	No No	Specify:				Specify: Wh	ite
15. Decedent's E			Sa Dacar	dent's Usual	Occupati	00			165	Vind of Business (I	
(Specify only highest gra			(Give	kind of work DO NOT use	done du	ring mos	t of worki	ng	160.	Kind of Business/I	ndustry
Elementary/Secondary (0-12)	College (	1-4or 5+)								II	
17. Father's Name (First, Middle, Last,	4		поп	nemakeı		8 Math	arie Name	(First, Middle	Majer	Home	
										ы Зинате)	
W. Atlee Burpee,								a D. Le			
19a. Informant's Name/Relationship (										or Town, State, Zi	
Thomas D. White/S	Son					Stre			re,	MD 2121	1
20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Domousi from	cama	of Dispo tery, crer	sition (Name natory or othe	of er place)			ate	20c.	Location - City or T	own, State
`4 □Donation 5 □Other (Specif			n Pa	ırk Cre	emate	orv.	02/0	1/2004	Ва	ltimore,	MD
21. Signature of Funeral Service Liber	1596									remation	
Kenthy S.	Di M	1100	1	oan ko	Tri	oute	Fund	eral an	d C	remation le, MD 20	Center
shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Meta	sach line. I <b>static Th</b> (or as a consequenc	•	d Cano	cer						Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	(or as a consequenc									
resulting in death) Last	Due to	or as a consequenc	e of):								
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  Part II. Other significant conditions of	1 ☐ Live b	come of pregnancy with 2 Petal dea ant at time of death own	ith 3 🗆 5 🗆	Ectopic preg Other (spec						23d. Date of deliv Month	ery Day Year
Part II. Other significant conditions of	contributing to d	eath but not resulting	in the u	nderlying cau	ise given	in Part I.					the cause of death?
	-							24a. Was	an	24b. Were auto	opsy findings available ompletion of cause of
25. Was case referred to medical						ie nie	of De C			lo 1∟Yes	2 □ No
examiner?	Hospital:	continue office	Numeric .					(Check only o			
27. Manner of Death	1 🔲	npatient 2 ER/0	Jutpatien . Time of		Innur a	4 LALNU		ne 5 □ Resid 28d. Describe I		6 ☐Other (Special	<i>fy)</i>
1 X Natural 5 ☐ Pending		of Injury 28b th, Day Year)	Injury	M	:. Injury a Work?	s 2 □ l		.03. 0030100 (	ion ail	ary occurred	
2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place	of Injury - At home, ng, etc. (Specify)	farm, str			5 2 🗀 (	-	88f. Location (S City or Tox		and Number or Rura te)	al Route Number,
29a. Certifier 1  Certifying Ph (Check only one) 2 Medical Exer	niner: On the b	best of my knowled asis of examination a ner stated.	ge, death and/or inv	occurred at vestigation, in	the time,	date and	d place, a	and due to the ad at the time,	cause(: date ar	s) and manner as s nd place, and due t	stated. the cause(s)

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

> State Registrar

Alpana Gonvani, 31. Date filed (Month, Day, Year) FEB 0 6 2004

29b. Signature and title of certifier

32, Registrar's Signature

30. Name and add ass of person and completed cause of death (Item 23a) (Type, Print)

Suite G-100; Rockville, MD 20852 Oural

29c. License number

D27660

29d. Date signed (Month, Dey, Year)

January 30, 2004

MID.

			State of Maryland / Department of Health a  Certificate of Death		Reg.	6004	03434
	Physicia	ın	Decedent's Neme (First, Middle, Last)     GENEVIEVE WINTERMUTE	2. Date of Monti	1	Dey Year	
	/Medic Examin			vn, or Location of	uary Deeth	4c. County of Dec	
				nsville_		Balti	more
	Funeral Director		5. Sociel Security Number 214-24-2508  Usuel Residence of Decedent  6. Sex 1 M 2 F 96  7. Age (In yrs. last birthday) Yrs.  96  Hours  H Under 1 Year Months Deys Hours	Min. 8. Date of (Mont)	of Birth h, Day, Ye L6/19	9. Bi	rthplace (State or Foreign Country) MD
	yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Se-fal	Director	MD Baltimore Catonsville				1 □ Yes 2 1 No
	with the	౼	10e. Street end Number 10f. Zip Code		10g.	. Citizen of Whet C	·
	me 23	Funeral	303 Maiden Choice Lane   21228     11. Marital Status   12. Was Decedent Ever in U,S.   13. Was Decedent of Hispenic Original France Original France Original France Original France Original France Original France Original France Original France Original France Original France Original France Original France Original France Original France Original France Origina	nn? (Specify Yes	or No-	14. Race - Am	
21215-0036			Armed Forces?  1 Never Merried 2 Married   1 Yes 2 No   1	, Puerto Rican, etc	:.)	Black, Wh	ite, etc. White
15-0	natul	eted	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most in Ife. DO NOT use retired)	of working	161	. Kind of Busines	s/Industry
212	filed withir Hygiena. other than	Completed by	Elementery/Secondary (0-12) College (1-4or 5+) Homemaker			Own Home	
pu	be filed Ital Hyg Id other event,	Be C		r's Name (First, M			
ylaı	should be ind Mental imarked o	٥		llian R.			
Maryland	d 2 sho th and 7 is me traum		Joanne Jesilionis/Daughter  19b. Mailing Address (Street and Number  3713 Ligon RD E11				
	f Health fem 27 other tr	1	20a. Method of Disposition 20b. Place of Disposition (Name of	Date		C. Location - City o	
mo	@ E + >		1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Crest Lawn Memorial Gar	c. 2/7/04	⊢ ⊩ Ma	rriottsv	ille. MD
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton				
_	80588		736 Edmondson Av	ve. Balti	more	, MD 212	
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cashock, or heart failure. List only one cause on each line.	cardiac or respirate	ory arrest,		Approximete Interval Between Onset end Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)  Due to (or es e consequence of):	2			Suz
		ē	Due to (or es e consequence of):				moth
	acuted and trensit	Examiner	Sequentially list conditions,  Due to (or es e consequence of):				1
68760,			Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury				1
687	- O O	edicai	that initiated events resulting in death) Lest  Due to (or as a consequence of):				 
Вох	laath certifi attending	Physician/M	d		<del></del>		1
	e daal the att hed fo	Sici	Part II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I.	23b.	Did tobac	cco use contribut	e to the ceuse of death?
P.O.	that the da led by the a datached i	P.	Demestica		1 🗌 Yes	2□ <b>No</b> 3□ F	Probably 4 Unknown
of Vital Records,	8 E 8	Completed by			Was an a		Were autopsy findings available prior to completion of cause of death?
Re	The law ite has	Ē	ć.		t'⊡Yae	21ZNo	1 ☐ Yes 2 ☐ No
/ital	ysician: The l s certificete hi director, paga	e B	examiner?	of Death (Check of	nly one)		
of	유투를	2				e 6 □Other (Spe	ecify)
	ding Ph th. : After th e funeral	틸	27. Menner of Deeth  1 Anaturel 5 □ Pending (Month, Day Year)  2 □ Accident investigation  28b. Dete of Injury (28b. Time of Injury Work?  1 □ Yes 2 □ No.		IIDe IIOW I	injury occurred	
Division	al or Attens a star dea	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		on (Stree r Town, S		Rural Route Number,
,	he Hospi in 24 hou he Funer pletely fil	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death end menner steted.	I plece, end due to h occurred et the t	the cause me, date	e(s) and manner e and place, and du	s steted. e to the cause(s)
)	1	2	29b. Signeture end title of certifier  Charles Rholan was 0247 81			Date signed (Mon	
	Q		30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  CHARLES R. GRAHAM DR MO (OUI PLE LIKE FUT.	1 ma	200	RALON	200 g
	Stat	_	31. Dete filed (Month, Day, Year) 32 Registrer's Signeture	- 100-	, , , , ,	13/1-11/7	الما مرا
,	Registra		FEB 0 6 2004				
DH	MH 16 Rev 6/95		ORIGINAL				

		•	For State Registrar	State of	Marylan	•	artment of H			jiene 🤵	004	0343.
			Decedent's Name (First, Middle, Last)						2. Date of Dea	th		3. Time of Death
	Physici		Richard Perry	500W	ina				JAN	Day	2-004	8 25/ M
)	/Medic Examin		4a. Fecility Name (If not institution, give s.				4b. City, Town, or	Location of Death	271	_	ty of Deeth	
	LXaiiii	ic.	10207 Windcopin	Circ	le		Columb	ni a		Howar	Ъ	
	Funeral		5. Social Security Number 6. Sex		. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	1	9. Birtho	lece (State or Foreign
п	Director		314-09-5154 XX	M 2□F	82	Yrs.	Months Days	Hours Min.	(Month, Day Oct. 21		Indi	* *
			Usuel Residence of Decedent						000.21	1 1 2 4 1		
	ylan		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
	Mar a-f at	tor	Calif. San Dieg	O	0ce	ansid	е					1 ☐ Yes 21X No
	r 28.	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Coun	try?
	h with		3174 Calle Osur				92054			US	7\	
	deat deat	Funeral		2. Was Deced			Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Ra	ce - Americ	
36	be filed within 72 hours after death with the Maryland tial Hygiene. bd other than "naturat", or tiems 23a or 28a-f ahow event, the Medical Examera must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dat	No		1 Tes, specily Cubai 1 □ Yes 2 🛣 No	Specify:	nicari, etc.)		ack, White, ify:whit	
Maryland 21215-0036	hour turns	edit	15. Decedent's Educ			16a Dece	dent's Usual Occupa	ition		16b. Kind of	Business/Inc	fustry
5	within 72 ene. then "net	Completed	(Specify only highest grade	completed)		(Give	kind of work done d	luring most of work	ing	TOD. KING OF	ousiness/in	ustry
2	withi ene. then	m	Elementary/Secondary (0-12)	College (1-	4or 5+)					D 1	. 1	
2	Hygie Hygie other	ပိ	17. Father's Name (First, Middle, Last)	5+		Doct	or	18. Mother's Name		Psych Maiden Suma		7
ğ	Mental   Mental   arked o	Be	Unknown								<u>-</u> /	
Ž	2 should be and Mental is marked of reumatic ev	L <sub>0</sub>	19a. Informant's Name/Relationship (Typ	a Drinel		10h Mailie	a Address (Counts	Unknown		. Cibe on Town	- Chata 7i-	Codel
<u>a</u>	s 1 and 2 should I Health and Men Item 27 is marks other traumatic					190. Mailir	ng Address (Street a	ina Number or Hur	ai noute Number	, City or Town	n, State, Zip	Code)
	l and lealth im 27 her tr		Jamie Wooding/wi	ie	20h F	3174	CAlle C	suna, Oc	eansid	e, Ca	lif.g	2054
altimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 💢 Re	moval trom S	ate	cemetery, crer	natory or other place	02/0	5/2004		·	
Ξ	Pa men men men men		* 4 ☐ Donation 5 ☐ Other (Specify)		Ва		ash.Crea	mtory		Laur	el, M	id.
a	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service License	1		22	. Name and Addres	s of Facility Wit	zke Fu	neral	Home	s,Inc.
<u>m</u>	205 2 9		14:040	1(		5	555 Twin	Knolls	PA C	Olumb	ia, M	d. 21045
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that ca	used the deat	th. Do not ent	er the mode of dying	, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	/1		lerot	10	ovascul	1	scose	3 II	Onset and Death
	/Medical		resulting in death)	-	r as a conseq		1- (21 01)	010030001	u I	SUGSO	9	IBOYS
Ю	Examiner			Cong	05 7	Vi 110	SOUT FOR	· lene			1,	1ears
į.		e			r as a conseq	juence of):	0111-0	Ciwo			17	1001-
	uted ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events								1	
	exect n and ial-tra	Exa	resulting in death) Last	Due to (o	r as a conseq	ruence of):			-	-		
8760	icate be executed physician and s the burial-transit	dicail										
89	ficate phy s the											
×	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outc	ome of pregna					23d. D	ate of delive	TV.
Вох	atter	ciar	in the past 12 months?		th 2□Feta nt at time of d		Ectopic pregnancy Other (specify)					Day Year
o.	that the de ed by the detached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknov			2 cme. (4,2cm,)/					
م	that the ed by detac	P.	Part II. Other significant conditions con-	ributing to dea	th but not res	ulting in the u	nderlying cause give	n in Part I.	23e. Did tol	bacco use cor	ntribute to th	e cause of death?
Records,	rires tha signed d be del	l by	OSTEODOYOSIS			-	, ,		1 🗆 Ye	es 2 No	3 ☐ Prob	ably 4 Unknown
0	w require been si should l	Completed	0010010000						200000000000000000000000000000000000000			
ec	hast ge 2 s	du							24a. Was a autops	n 24b.	prior to con	bsy findings available inpletion of cause of
-	The page	S							perform 1 ☐ Yes	2 No	death? 1 🗌 Yes	312 No
Vital	Physician: this certificated rail director.	Be	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only on	e)		HOTEL
	hysion his co	ပ္	Tes 2 No	-		ER/Outpatier	t 3 DOA Othe	4 Nursing Ho	me 5 Reside	ence 6 Dot	her (Specify	1300 m
Division of	To the Hospitat or Attanding Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury	Work	at ? ∕es 2 □ No	28d. Describe ho	ow injury occu	irred	
S	ttandil death. ctor: A y the fu	ica	3 ☐ Suicide 6 ☐ Could not be	28e Place o	f Injury - At he	ome tarm str	eet, factory, office		28t. Location (St	reet and Num	nher or Rura	Route Number
<u>&gt;</u>	t or A after Direction by	erti	4 ☐ Homicide determined	building	g, etc. (Specif	(y)	301, 1201019, 011100		City or Town	n. State)		, , , , , , , , , , , , , , , , , , , ,
	To the Hospitat or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Phys	ician: To the b	est of my kno	owledge, deatl	occurred at the tim	e, date and place,	and due to the ca	ause(s) and m	nanner as st	ated.
	the H sin 24 the Fi	Medical	one)	and manne	or stated.	LOUI ALLOVOF IN	opt-					
	To To	2	29b. Simature and the of certifier		-	1 apai	29c. License	number	2	9d. Date sign	ed (Month, L	Day, Year)
			Talver H	Jour	no	mE	1314	175	- 1	Leb- 1,	2000	+
	V	- 13	30. Name and address of person who con	nplet d cause	of death (Iten	n 23a) (Type.	Print)	1	1	. 44 -		,
	-		YATRYCE A. 104	E, M.	D 45	765/	tem lak	cne W	all =1/10	oll (i	14 M	121042
2	Sta	ate	31. Date tiled (Month, Day, Year)	32. Re	pistrar's Signa	ature	ø				/	
	Regist	rar	EER 0 6 20	04	Robert	All A						

State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND ITEM #29d PER PHY G828 2/11/@Ac**rt**ificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year MARIE **FEBRUARY** 2004 12:00 P.M WAYBRIGHT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Director 212-34-4810 68 Oct. 4, 1935 W. Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location. 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2000 Directo Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 827 LaGrange Road 21154 or Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2010 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married MX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 💥 No Specify: þ Specify: 3 Widowed 4 Divorced 'natural', White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other treumatic event, 900. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) John Taylor Price ပ Minnie Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Marie Mullaney-Daughter 823 LaGrange Road, Street, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial 2/5/04 Fallston, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensed 1317 Cokesbury Rd., Abingdon, MD 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Sepais resulting in death) /Medical Due to (or as a consequence of): **Examiner** -0-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) burial-P.O. Box 68760. sician Physician/Medical the phys as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, certificate has been si rector, page 2 should I 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) I in by 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled Hospitel within 24 hours a 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ţ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 29c. License number FEBRUARY 03,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day,135 615 W. Ma-31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar 6 2004

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State of Maryland / Department of Health and Mental Hygiene

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8	d within 72 hours after death with the Maryland jiene. pene. In than "natural", or Items 23a or 28e-f show than "natural" or Items 21a or 28e-f show the Walled Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		7 140	Specify.		Specify: Wni	te 
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Maryland 21215-0036	2 should and Men Is marke	F	19a. Informant's Name/Relationship (7		19b. Mailin	a Address (Street			City or Town, State, Zip	Code)
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Division of	or At	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre (fy)	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
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	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: Attoumpletely filled in by the funerel or mpletely filled in by the funerel process.	Medical	(Check only 2 Medical Exami	sician: To the best of my kni iner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place pinion, death occu	), and due to the cau irred at the time, dat	use(s) and manner as sta e and place, and due to	ated. the cause(s)
	o the o the mple	Me	29b. Signature and title of certifier	and mariner stated.		29c. License	number	29	d. Date signed (Month, D	Day Year)
	FSFO		) con &				5353		01/29/10	
	E	-	30. Name and address of person who co		m 23a) (Type E		1757		1 67/16	(
	<u> </u>		L CALLY	The state of the s	10a) (Type, F	Post	da 1	al do	0.65	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Court.	11.01	2	112	
	Registra	ar	FEB - 6	2004 ▶ №	. 14	Coracle 5				

			1 - For State Registrar	State	of Mar	yland / Dep <i>Ce</i>	artment of I rtificate of	lealth an <i>Death</i>	d Mental F	lygier Reg. N		0340
	Dhysioi		1. Decedent's Name (First, Middle,	Last)					2. Date of Month		ay Year	3. Time of Death
	Physici /Medic		Maurice	Wilson	n		Bozman		Janua		3, 2004	1:14PM M
	Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town, o	or Location of D	eath	4	c. County of Death	
			Atria Salisbury				Sali	sbury			Wicomico	
	Funeral Director		5. Social Security Number 214–32–0748	S.Sex 100 M 2□F		In yrs. last birthday 69 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of (Month, 04/13	Birth Day, Yea /193	9. Birthpi Coun 4 Mary	lace (State or Foreign try) 1and
	pu »		Usual Residence of Decedent  10a. State 10b. County			0c. City, Town or L						
	shor	<u></u>	Tob. County		1.	oc. ony, rown or E	ocation				"	0d. Inside City Limits 1 Yes 2 □ No
	88a-1	ecto	MD Wicomi	.co		Salisbur				T		
	with t	Ē	10e. Street and Number				10f. Zip Code	01001		10g. C	Citizen of What Coun	try?
	eath	erai	503 Tony Tank I	lane	codent Ev	or in II S 12		21801	2 (Consider Van au	No	USA 14. Race - America	an Indian
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, Ir a Madical Examination and the indiffied all sone.	by Funeral Director	1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed F	orces? 2 No Give	er iii 0.3.	Was Decedent of H If Yes, specify Cub 1☐ Yes 2 No	an, Mexican, Pi	uerto Rican, etc.)	NO-	Black, White, e	etc.
3	thou sture	ed	15. Decedent's	Education		16a. Dece	dent's Usual Occur	ation		16b	Kind of Business/Ind	hite
C 7 7	within 72 ene. than "ne re Madi	Completed	(Specify only highest Elementary/Secondary (0-12) 1 2	grade completed College	1) (1-4or 5+) 5+	life.	dent's Usual Occup kind of work done DO NOT use retire	during most of d)	working		College	33.Iy
5	filed Hyg other ant,	Ö	17. Father's Name (First, Middle, La			1101	.68801	18. Mother's	Name (First, Mide			
<u> </u>	ld be ental kad d	To Be	Oliver Frederic	k Bozma	n			Lillia	n Warwic	k		
	shoul mark	Ε.	19a. Informant's Name/Relationshi			19b. Maili	ng Address (Street				or Town, State, Zip	Code)
Ž	Ith all		Carole Kirkwood		/Wife		Tony Tan					,
Ď,	s 1 ar		20a. Method of Disposition	,		20b. Place of Disponentery, cre			Date	-	Location - City or Tox	wn, State
2	Pages ant of nt: If i		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	B □Removal from	n State			1	106 10001			150
allillo	artm ortar ortar injur		21. lignature of Funeral Septice Li	1	)	2	d Cemete  Name and Addre	ss of Facility		Pr	incess Anı	ne, MD
Ö	permi Depar Impo any ir	(	I was AN	www	M002	H	inman Fun	ieral Ho	ome, 116	573 5	Somerset A	venue
			23a/ Part1. Enter the disease, or c shock, or heart failure. List of	omplications that	caused th	e death. Do not en		ng, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	a. Lav Due to	o (or as a c	consequence of):	5 N	12 Pa	se			
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a c	consequence of):						
	ted nsit	Examiner	Cause (Disease or injury		(5. 45 4 6							
	xecu and al-tra	xar	that initiated events resulting in death) Last	c. Due to	o (or as a c	consequence of):						
9	ficate be executed physician and s the burial-transit	alE										
000	icate phys	edical		d								
Š	certii nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or							23d. Date of deliver	n/
	the death y the atter iched for u	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at tim		Ectopic pregnancy Other (specify)	<i>y</i>		-		Day Year
Lo,	To the Hospital or Attanding Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use and	ρ	Part II. Other significant condition	s contributing to	death but r	not resulting in the u	nderlying cause giv	en in Part I.			use contribute to the	
3	w rec	ompleted		•	,				24a. W	as an	24b. Were autop	esy findings available
ב	he law e has l age 2 s	Ë							– au	topsy rformed?	prior to com death?	pletion of cause of
9	ificat or. p	ပိ	25. Was case referred to medical	-				OR Floor &		2 2 N	o 1 ☐ Yes 2	2 ∐ No
>	s cert irect	o B	examiner?	Hospital:	]Inpatient	2 ER/Outpatie	nt 3 DOA Oth	or /	Death (Check only	0 1 1 1 1	C [] ()	-
5	Phy or this aral d	$\vdash$	27. Mann of Death	28a. Date	of Injury	28b. Time o			28d. Describ		6 □Other (Specify) urv occurred	
5	th. : Afte	ţ	1		nth, Day Y	ear) Injury		k? Yes 2∐No		,	•	
2	Attar r dea actor by the	ertification:	3 ☐ Suicide 6 ☐ Could no	t be 28e. Plac	e of Injury	- At home, farm, st	eet, factory, office		28f. Location	(Street a	and Number or Rural	Route Number,
5	s after	Cert	4 Homicide determin	buile	ding, etc. (	Specify)			City or 7	own, Sta	te)	
	To the Hospital or Attanding Physician: The within 24 hours after death.  To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	edical (	29a. Certifier 1 Certifying (Check only one) 2 Medicel Ex	ceminer: On the	ne best of n basis of ex nner stated	ramination and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the	e cause( e, date ar	s) and manner as sta nd place, and due to	ted. the cause(s)
	To the within To the Comp	Me	29b. Signature and title of dertifier	7	_		29c. Licens	e number		29d. 9	ate signed (Month, D	ay, Year)
			11/1/201	ber			D00	25 6	74	1/	27/01/	
	An		30 and address of person w	no com let d cau	use of deat	th (Item 23a) (Type,	Print)		iond	Ĺ	207,	. /
	00		JA LOCK	ey(N	20	127	0 .	21015	riond	77	Jakob	Ury Mil
	Sta Registra	-	31. Date filed (Month, Day, Year) FEB - 6	2004	Pegistrar's	s signature	ester.					2480 Y

			For State Registrar	State of Ma	aryland	d / Depa <i>Cer</i>	rtment of F tificate of	Health and N <i>Death</i>	Mental Hy	/giene 2 Reg. No.	004	0344
			1. Decedent's Name (First, Middle, La	ist)					2. Date of D		Year .	3. Time of Death
	Physicia /Medic		Jane Ellen	Buhrman					Janua		2004	1130pm
	Examin		4a. Fecility Name (If not institution, gi				4b. City, Town, o	or Location of Death		4c. Coun	ty of Death	-1.
			Fahrney-the			Home	1200r	Sport	1	. Wa		aton
	Funeral			Sex 7. Ag 1 ☐ M 2 🟋 F	e (In yrs <b>)</b> la	ast birthday) . Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bi (Month, D May 24	ay Year)	Cour	State or Foreign htry) Land
	Director		Usuel Residence of Decedent					_11	ray 24	, 1722	rialy	Tallu
7	yland		10a. State 10b. County		10c. City	, Town or Loc	cation				1	0d. Inside City Limits
8	Mar st	ctor	Md. Washin	gton		S	abillasv	ille				1 □ Yes 2 No
2	ith the Marylar or 28a-f show	Olre	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cour	itry?
E	after death with the Maryland or itams 23a or 28a-f show infrar must be notified at	Funeral Director	24958 Raven Ro					1780			J.S.A.	
3	er de Itams	une	11. Marital Status	12. Was Decedent Armed Forces?		5. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14. H	ece - Americ ack, White,	
Bu <b>hik</b> mar	Ir, or	by F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 🔯 I If Yes, Give Year or Dates:	40	1	☐ Yes 2X No	Specify:		Spec	ity: Whi	te
E. B	2 hou	ted	15. Decedent's E	ducation		16a. Deced	ent's Usual Occup	pation	-1	16b. Kind of	Business/Inc	dustry
m <sup>2</sup>	thin 7 B. Med	pie	(Specify only highest gamestary/Secondary (0-12)	College (1-4or 5	5+)	life. C	OO NOT use retire		ung			
7 757	ed wil	Completed					Homema			1	me	
<b>3 2</b>	be filted Hydrau even	Be	17. Father's Name (First, Middle, Las					18. Mother's Nam			ame)	
.ਨੋਵੈ	d Mer nerke	2	Jennings D. Pryc  19a. Informant's Name/Relationship			10h Mailin	a Addrage /Stract	Marga t and Number or Rui	ret E.		a State Tin	Codel
Ma	d 2 sl th an t7 is t		Lea J. Geist (Da			1		ail Marti				0000)
, ē,	s 1 and 2 should be tited within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of patory or other pla		Date	20c. Location		wn, State
6	Peges ent of nt: If I		1 XBurial 2 ☐ Cremation 3 ☐ Other (Spec			-	emetery	Jan.	28, 2004	Casca	de,Md	
Baltimore	permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, the Medical Eve once.		1. Signature of Funeral Service Lice	nsee		22	Name and Addre	ess of Facility	12525 F	radbury	Ave.	
ω_	88 = 8		Jennis &	· My	in	) Dav	vis Fune	ral Home	Smithsb	urg,Md.	2178	3
			23a. Mart1. Enter the disease, or conshock, or heart failure. List on	nplications that caused one cause on each li	the death	. Do not ente	er the mode of dyi	ing, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a CONG	ESTI	VE	HEART	- PAIL	URE			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	rence of):	•					
		- G	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequ	ience of):						
	uted 1	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			,						
ó	exection and and rial-tra		resulting in death) Last	Due to (or as	a consequ	ence of):						
8760,	cate be executed physician and the burial-transit	dicai	•	_ d								
9	ntifica ing ph e as tl	Med	IF FEMALE:									
30,	eath certifi attending   I for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3 🗆	Ectopic pregnanc	;y		!	ate of delive Month	ery Day Year
0.	he de the a	ysic	1 ☐ Yes 2 ⊠No 9 ☐ Unknown	4□ Pregnant al 9□ Unknown	t time of de	eatn 5	Other (specify) _					•
مَ	w requires that the death cer been signed by the attendin should be detached for use	by Physician/Me	Part II. Other significent conditions	contributing to death b	ut not resu	ılting in the un	derlying cause gr	ven in Part I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?
sp	uires Isign Ild be								1 🗆	Yes 2□No	3 🗆 Prob	abiy 4 Dûnknown
00	s beer	Completed							24a. Wa		. Were auto	psy findings available
Re	The la	mo							auto perf	ormed?	prior to cor death? 1 \( \text{Yes} \)	mpletion of cause of
ital	ian: rtifica	BeC	25. Was case referred to medical examiner?					26. Place of Dea				
> >	hysic his ce	To	1 ☐ Yes 2 No	Hospital: 1   Inpatie		ER/Outpatient	3 DUA		ome 5 Res	idence 6 🗆 O	ther (Specify	r)
o u	ing P	on:	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe	how injury occi	urred	
Sio	ttend death tor: /	icat	2 Accident investigati 3 Suicide 6 Could not	be 380 Place of Ini	iun. At ho	me form etre	M 1 Det, factory, office	Yes 2 No	28f Location	(Street and Num	hor or Pura	J Route Number,
Division of Vital Records, P.O. Box	after Direction by	Certification: To	4 Homicide determine	building, et	c. (Specify	')	ser, ractory, ornos		City or To	wn, State)	iber of fibre	, rioute runnou,
	spite		29a. Certifier 12 Certifying F	hysician: To the best	of my knov	wledge, death	occurred at the ti	ime, date and place,	and due to the	cause(s) and r	nanner as st	ated.
	To the Hospitel or Attending Physician: The law requires that the death certifin within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medicai	(Check only Z Medical Execute)	miner: On the basis o and manner st	t examinati ated.	ion and/or inv	estigation, in my	opinion, death occur	rred at the time	, date and place	e, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		>		29c. Licen:	se number		29d. Date sign		Day, Year)
	,0			1910			DS	5252		6//2	6/06	
ò	1		30. Name and address of person who				·	, Ucasa	4 363	017/0		
7	Sta	ite	Khalid M. Waseem 31. Date filed (Month, Day, Year)	M.D. 194]	ar's Signat	Leiter:	sburg Pi	ke Hagers	LOWn, Md	21/42		
	Regist		JAN 27	2004 Jane	,44/	O. Sp	will					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	/larylan	d / Depa	artment of F	lealth Death	and Mental Hy	/giene2		03	
	Dhuaiai		1. Decedent's Name (First, Middle, L.	ast)					2. Date of De		Year	3. Time	
_	Physicia /Medic		LINDA DARNELL	BOWERS					JANUA		2004	21	.05 м
	Examin		4a. Facility Name (If not institution, gi		r)		4b. City, Town, o			4c. County		rateme	NAT.
			21504 BLACK ROCK		las (la um l	fo o a bi-ab-day i	If Under 1 Year		RSTOWN  24 Hrs. 8. Date of Bi	rth	WASHI		
и	Funeral Director			1□M 2XF	54	last birthday) Yrs.	Months Days	Hours	Min (Month D	4, 1949	Countr MA	RYT.A	or Foreign
			Usual Residence of Decedent					1	1101.	. 1, 2010	111		110
	ylanc		10a. State 10b. County		10c. City	y, Town or Lo	cation				10		City Limits
	e Ma	cto	MARYLAND WAS	HINGTON			HA.	GERS	COMN				s 2X No
	or 28	Dire	10e. Street and Number	Z DOAD			10f. Zip Code	2174	0	10g. Citizen of V	Vhat Counti U.S.A		
	be filed within 72 hours after death with the Maryland ital Hygiene dother than "naturel", or items 23a or 28a-f show event, I're Medical Examiner must be netified at	Funeral Directo	21504 BLACK ROCI	12. Was Deceder	t Ever in II	C 12	Mac Decedent of h			0- 14 Race	e - America		
	item iner	Ë	11. Marital Status  1 ☐ Never Married 2 🕅 Married	Armed Forces	57	3.	f Yes, specify Cub	an, Mexica	rigin? (Specify Yes or N n, Puerto Rican, etc.)	Blac	k, White, et		
36	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	-		1 ☐ Yes 2 🗓 No	Specify	•	Specify	" WH	ITE	
2-0036	72 ho	Completed	15. Decedent's 8	ducation		16a. Dece	dent's Usual Occup	ation	st of working	16b. Kind of Bu	isiness/Indu	ustry	
2	within 7 ene. then "r	npie	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	kind of work done			ACCTOM	21) T T T	TINC	HOME
2	filed w Hygier other th	ပိ	11 Sathada Nama (Simt Middle / as	4)			OWNER/OP		er's Name (First, Middle	ASSISTI		/TING	HOPLE
and	ould be fi Mental H larked otl	Be	17. Father's Name (First, Middle, Las WILBERT WESLEY						LINE THOMAS		θ)		
Maryland	ages 1 and 2 should be int of Health and Menta t: If Item 27 is marked y or other treumatic ev	ပ္	19a. Informant's Name/Relationship			19b. Mailii	ng Address (Street	and Numb	er or Rural Route Numb	per, City or Town,	State, Zip C	Code)	
<u>≅</u>	and 2 salth ar n 27 is ser treu		CHARLES C. BOWE	RS. SPOUSE	C	2150	4 BLACK	ROCK	ROAD, HAGE	RSTOWN, N	4ARYLA	AND	21740
ē,	s 1 and Head Head Item		20a. Method of Disposition		20b. P	lace of Dispo emetery, crei	sition (Name of natory or other pla	ce)	Date	20c. Location -	City or Tow	vn, State	
altimore,	Pages nent of nnt: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 14 ☐ Donation, 5 ☐ Other (Spec		e i	-	N MEM. PA		JAN. 28, 04	HAGERST	OWN, 1	MARYI	LAND
Balt	permit. Pag Department Importent: I any injury o		2). Signature of a retal service Lice Relly A Zim	nerman			. Name and Addre		10ME /000 (	OLD NATIO			L713
			23a. Part 1. Enter the disease, or co	inplications that cause	ed the death	h. Do not ent	er the mode of dyir	ng, such as				Approxima Interval Be	ate
-	Physician		shock, or heart failure. List online Immediate Cause (Final	one cause on each		FAIL	URE					Onset and	d Death
	/Medical		disease or condition resulting in death)	a	as a consequ		.0110					Y EM	
	Examiner		Sequentially list conditions	b. ME	TAST	ATIC	PANCRE	ATIC	- CANCE	R.	1	YEA	R.
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequ	uence of):							
	and P-trans	Examiner	that initiated events resulting in death) Last	c Due to (or a	as a consequ	uence of):							
760,	death certificate be executed e attending physician and ind for use as the burial-transit	icai E											
687	tificate ig phy: as the	edic	92	u									
Box	ath certif attending for use a	M/G	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1□Live birth		incy Ldeath 3	Ectopic pregnanc	v			e of delivery	•	
о. В	e death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant 9☐Unknown	at time of de		Other (specify)			Moi	ntn L	Day	Year
<u>Р</u> .	nat Ihe d by ti etach	Phy	9 ☐ Unknown  Part II. Other significant conditions	contributing to doath	but not root	ulting in the u	adorhina sauco an	on in Part	1 23e Did	tobacco use contr	ibute to the	a cause of	f death?
ŝ	The law requires that the de ste has been signed by the a page 2 should be detached t	by	Part II. Other significant conditions	Contributing to death	TOUT HOT 163	unting in the u	ilderlying cause giv	on in rait			3 Probai		Unknown
Records,	w require been si should I	Completed							24a. Was	24h V	Nore autono	sy finding	e available
Rec	has be 2	du							auto perf	ormed? c	Vere autops prior to com leath?		cause of
		0	25. Was case referred to medical					26 Plac	1 ☐ Yes e of Death (Check only	-7	☐ Yes 2	2 □ No	
<u> </u>	ysicie is cert direct	To B	examiner? 1 ☐ Yes 2 ☐ Vo	Hospital:	tient 2	ER/Outpatier	nt 3 DOA Ott		ursing Home 5X Res		er (Specify)	)	
0			27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of In (Month, D	njury Day Year)	28b. Time o Injury	f 28c. Injur	ry at	28d. Describe	how injury occurr	ed		
<u> </u>	Attending Ph er death. ector: After th by the funeral	atic	2 ☐ Accident investigati	on			M 1	Yes 2					
Division of Vital	l or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	289. Place of I	njury - At ho etc. (Specify		eet, factory, office			(Street and Numbi own, State)	er or Rural .	Route Nu	mber,
_	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	(Check only 2 Medical Ex	miner: On the basis	of examina	wledge, deat tion and/or in	h occurred at the tive vestigation, in my o	me, date a	nd place, and due to the ath occurred at the time	cause(s) and ma date and place, a	nner as sta	ted. the cause	(s)
	thin 2 the c the	Med	one) 29b. Signature and title of certifier	and manner	s(a(90.		29c. Licens	se number		29d. Date signed	(Month, D	ay, Year)	
)			1 2+	12	7		D44	996	, c	Januar			
,	145		30. Name and address of person wh	completed cause of	f death (Iten			2,0	60				
2			ZAFAR M.	ALIK ME		0311 6	APPANS	Ro	BOONSBO	RD MI	) 21	113	
	Sta Registi		31. Date filed (Month, Pay, Year)	2004 32. Regis	strar's Signa	iture	rester						
	riegisti	4.21		-voi	4300	N. 13	NO PORT						

			nended Item #5 CHD/SH 1/27/04 per	State of Maryla	and / Dep		of He	ealth ar	•	Hygiei	_ < U	104	0544
		н	1. Decedent's Name (First, Middle, Las						2. Dete d		Dey	Year	. Time of Death
1	Physicia /Medica		Henry M	larise		Burnet			Janu	ary 2	25, 20	004 9	9:30 A.M.
1	Examine	-	4a Fecility Neme (If not institution, give					•	n, or Location of I	Deeth	4c. County		
			Coffman Nursing	Home				agerst				Ington	
	Funeral Director	-	5. Social Security Number 6. S 248-14-8822 2 Usual Residence of Decedent	9x 7. Age (In y 82	rs. last birthday) Yrs.	If Under 1 Months		If Under 24 Hours	Min. 8. Date of (Monto) Aug.	of Birth h, Day, Ye 5, 1	.921 \$	9. Birthplace Country) South C	e (State or Foreign Carolina
	f show	5	10a. State 10b. County  MD Washingto		City, Town or Lo Inkstown								Inside City Limits  1 Yes 2 □ No
	ath with the Marylar 23e or 28e-f ehow	Funeral Director	10e. Street end Number 111 E. Green St.		III COWI	10f. Zip 0					Citizen of V	Vhat Country?	,
	23 ath	a l		12. Wes Decedent Ever in	116 12			nonlo Origin	n2 /Specify Ves			e - American I	Indian
020	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or flems 23s or 25s-f show out, the Medical Examiner must be notified at	by Fun	11. Maritel Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1∑ Yes 2 □ No If Yes, Give Year or Detes:		If Yes, specif		Specify:	n? (Specify Yes o Puerto Rican, etc	i.)		k, White, etc.	
Maryland 21215-0020	in 72 hou	Completed by	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual kind of work DO NOT use	done de	uring most o	of working	16b	Kind of Bu	usiness/Indust	ry
72	Hygiene.	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	Gener	cal Ma	nage	r		E	levato	or Indu	ıstry
B		ပ္	17. Father's Neme (First, Middle, Last)		GCIICI	Lar na			s Name (First, M	iddle, Maid	ten Sumam	10)	
an	SEP 6	Be C	Benjamin H. Burn	ett				Lola	Mae Dunc	an			
2	2 should be end Menta is marked sumatic ex	۹	19a. Informent's Name/Relationship (1		19b. Meili	na Address			or Rural Route N		ly or Town,	State, Zip Coo	de)
	trau		James W. Burnett/						agerstov				
Baltimore,	Hee other	-	20a. Method of Disposition	200	Place of Dispercemetery, cre				Date			City or Town,	State
ou Ou	Pages nant of int: If its		1  ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	st Have				1/28/2	004 н	agers	town.	MD
Ė	permit. Pag Departmant Important: I any injury o	-	21. Signature of Funeral Service Licen			2. Name and		s of Fecility	1				
Ва	Deper		can be						Rest Ha			-	
		4	S. Whale Su	Δ					a Ave.				1742 proximate
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or conshock, or heart failure. List only Immediate Ceuse (Finel disease or condition resulting in death)	Metast.	o (or es a conse	lon	/	auli					erval Between nset and Death
	nsit	Examiner		b									
_	be executed sician and burial-transit	Xa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or es a conse	quence ot):						1	
x 68760,	nysicia he bur	E Ca	cause, Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	c. Due to	o (or as e consec	quence of):							
Вох	ath c	ᇤ										<u> </u>	
P.0.	0 0 2	P S	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	inderlying ca	use give	n in Part I.	23b.	Did tobac			e cause of death? Iy 4 ☐ Unknown
Records,	8 5 4	leted by							24a.	Was an au performed	itopsy	availat	autopsy findings ble prior to etion of cause th?
al Re	cate has b	Completed								1 🗆 Yes	2 1 No		es 2□No
Vital		E E	25. Wes case referred to medical examiner?	Hospitel:			Othe		Death (Check				
o	P S S	2	1 Yes 2 No	1 L Inpatient 2	ER/Outpatie			4 Murs	ing Home 5				
	After After	Certification:	27. Menner Deeth  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be			М		? ′es 2 □ No	0		njury occurr		
Divi	tal or Attencers after death	Certif	4 Homicide determined	28e. Plece of Injury - A building, etc. (Spe	t home, farm, st	reet, factory,	office			on (Street or Town, St		er or Rural Ro	)ute Number,
	Hospi 24 hour Funer tely fill	edicai		ysician: To the best of my inter: On the besis of exam and manner stated.									
		Σ	29b. Signature end title of certifier	1447		29c.	License	number		29d.	Date signed	d (Month, Day	( Year)
	180		DITTIVE   CKA	w, mis		05	60	22	4	IA	W. 2	6;2	004
4	John Sm		30 Name and eddress of person who o	completed cause of death (I	tem 23e) (Type	Print) 701/e	20	0.4	Hot gents	nun	, m	n ni	140
7	State Registra		31. Date filed (Month, Day, Yearly 20	32. Fegistrer's Signature	gnature M. Ag	well		+ /	y				

DHMH 16 Rev 6/95

an	1 - For State Registrar		Ce		Death	Reg. 2. Date of Death	No.	3. Time of De
	1. Decedent's Name (First, Middle, Last)						Day Year	
al	Ronald Lee Coss  4a. Facility Name (If not institution, give s	street and number)		4h City Town	or Location of Death	January :	4c. County of Death	1948
er	Washington Coun		al	Hagers			Washing	
	5. Social Security Number 6. Sex		yrs. last birthday) 57 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Feb 17	9. Birth	place (State or F untry)
	Usual Residence of Decedent			l		reb 17	1340 Ma	ryland
	10a. State 10b. County		. City, Town or Lo					10d. Inside City I
tor	Maryland Washing	ton H	agerstov	m				1 Yes 2
i Director	10e. Street and Number 18906 Monticello	Drive		10f. Zip Code 21742		10g.	U.S.A.	untry?
by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 X Yes 2 □ No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Cub  X 1 Yes 2 No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Whit Specify:	, etc.
Completed	15. Decedent's Educ (Specify only highest grade	cation e completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of works d)	ing 16b	. Kind of Business/li	ndustry
E O	Clementary/Secondary (0-12)	2	Pr	esident/	Photograph	ny Z	Advertisin	ng Compa
Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	First, Middle, Maid	den Sumame)	-
70 E	Frank Kenneth Coss				Catherine	e Elizabet	ch Keyser	Coss
	19a. Informant's Name/Relationship (Type			_	and Number or Rura		-	
	Christine H. Coss/				ello Dr. H			
	20a. Method of Disposition  5 Burial 2 Cremation 3 Re	emoval from State	D. Place of Dispo cemetery, cre	osition (Name of matory or other pla	сө)	Date 20c	. Location - City or T	own, State
	*4 □Donation 5 □ Other (Specify)	Re		n Cemete		24,2004 F		
	21. Signature of Funeral Service License	19			ess of Facility Dou			
- 3	/ Mucho A-	Xing			rn Blvd. I			
1	23a. Part1. Enter the disease, complice shock, or he failure. List only on	ne cause on each line.			_			Approximate Interval Betwee Onset and Dea
	Immediate Cause (Final disease or condition	Acute	Resp	irohm	Gilune			30 mini
	resulting in death)	Due to (or as a con	sequence of):	1	. 1			٠,
<u>-</u>	Sequentially list conditions, b	Due to (or as a con	יין ליין	Inorgy	Grilore	here		Thr.
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1						1 1-
хап	that initiated events c resulting in death) Last	Due to (or as a con	nsequence of):	- C				6 , 10
cai E								
edic								
cian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	Fetal death 3[	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deliving Month	very Day Yea
S	9 □Unknown	9□ Unknown						
F	artii. Ottor significant conditions con	tributing to death but not	t resulting in the u	inderlying cause gi	ven in Part I.		co use contribute lo	
d by Physi								
by						24a. Was an	24b. Were aut	opsy findings ava
by						autopsy performed	prior to co	ompletion of caus
Completed by					26 Place of Doub	autopsy performed 1 ☐ Yes 2 ☐	prior to co	ompletion of caus
Be Completed by	25. Was case referred to medical examiner?	lospital: 1 Appatient	2 □ EB/Outbatio	01 3 DOA 01		autopsy performed 1 Yes 2 2	prior to condeath?  No 1 □ Yes	ompletion of caus
To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 28a Date of Injury (Month, Day Yea	2 ☐ ER/Outpatie	f 28c. Inju	ner: 4 ☐ Nursing Ho ry at rk?	autopsy performed 1 Yes 2 2	prior to death? No 1 Yes	
To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No	28a. Date of Injury	28b. Time of Injury  At home, farm, st	M 1	ner: 4 □ Nursing Ho ry at rk?  Yes 2 □ No	autopsy performed 1 Yes 2 2 th (Check only one) me 5 Residence	prior to cideath? 1 Yes  6 Other (Specinjury occurred	ompletion of caus  2□ No  ify)
Certification; To Be Completed by	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Yea	28b. Time of Injury  At home, farm, stoccify)	M 1 Creet, factory, office	ner. 4 Nursing Ho ry at rk? Yes 2 No	autopsy performed 1 Yes 2 1 Am (Check only one)  me 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Stand due to the caust	prior to cideath? 1 Yes  6 Other (Specinjury occurred  t and Number or Ruitate)	ompletion of caus  2 No  ify)  ral Route Number
To Be Completed by	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Yea  28e. Place of Injury - building, etc. (Sp  sician: To the best of my ner: On the basis of exam	28b. Time of Injury  At home, farm, stoccify)	M 1 Creet, factory, office	mer. 4 Nursing Ho ny at rk? Yes 2 No me, date and place, opinion, death occurr	autopsy performed 1 Yes 2 1 Am (Check only one)  me 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Street at the time, date	prior to cideath? 1 Yes  6 Other (Specinjury occurred  t and Number or Ruitate)	ompletion of caus  2 No  ify)  ral Route Number  stated.  to the cause(s)
edical Certification; To Be Completed by	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Yea  28e. Place of Injury - I building, etc. (Sp  sician: To the best of my ner: On the basis of exar and manner stated.	28b. Time of Injury  At home, farm, stoecify)  I knowledge, deal mination and/or in	M 1 Creet, factory, office the occurred at the toestigation, in my 29c. Licen	mer. 4 Nursing Ho ny at rk? Yes 2 No me, date and place, opinion, death occurr se number	autopsy performed 1 Yes 2 1 Am (Check only one)  me 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Street at the time, date 29d.	prior to cideath? 1 Yes  6 Other (Special Injury occurred)  t and Number or Ruitate)  e(s) and manner as and place, and due  Date signed (Month)	ompletion of caus  2 No  ify)  ral Route Number  stated. to the cause(s) , Day, Year)
edical Certification; To Be Completed by	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Yea  28e. Place of Injury - Indust	At home, farm, stoecify)  Ak home, farm, stoecify)  knowledge, deal mination and/or in	of   28c. Injunction   28c. Injunction   28c. Licen   29	me, date and place, opinion, death occurres number	autopsy performed 1 Yes 2 1 Am (Check aniv ane)  me 5 Residence 28d. Describe how in 28f. Location (Stree City or Town, Streed at the time, date 29d.	prior to cideath?  1 Yes  6 Other (Specinjury occurred)  1 and Number or Rulate)  e(s) and manner as and place, and due  Date signed (Month)	ompletion of caus  2 No  ify)  ral Route Number  stated, to the cause(s)  , Day, Year)

			For State Registrar	State of Mary		artment of I ertificate of			giene	04 08445
E	D		1. Decedent's Name (First, Middle, Last)					2. Date of De. Month		3. Time of Death
	Physici: /Medic	al	Cecil Newton Clari					January		0730 AM
	Examin		4a. Facility Name (If not institution, give s	treet and number)			or Location of De	ath	4c. County	
3			Washington County 5. Social Security Number 6. Sex		yrs. last birthday		stown If Under 24 H	rs. 8. Date of Bir		gton County  9. Birthplace (State or Foreign
Н	Funeral Director		100	M 2□F	71 Yrs.	Months Days		n (Month, Da	y, Year)	Country) Bahamas
0			248-56-0473 Usual Residence of Decedent					, , , ,		
	rylan thow		10a. State 10b. County	10	c. City, Town or I	ocation				10d. Inside City Limits 1 ☐ Yes 2 X No
	Ba-f.	Director	Maryland Washington	a Co.	Smiths				40-07	
	With th	Dire	10e. Street and Number	_		10f. Zip Code			10g. Citizen of W	
	18 236	era	11626 Wolfsville Ro	Dad P.O. Bo	0X 398	21783 Was Decedent of	Hispanic Origin?	(Specify Yes or No	U.S.A 14. Race	e - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 is marked other than "naturel" or items 23a or 28a-f show any highly or other treumatic event, I'm Medical Exacilizar most be notified at another.	by Funeral	1 Never Married 200 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 1 No If Yes, Give Year or Dates:		If Yes, specify Cut  1 ☐ Yes 2 No	oan, Mexican, Pu	èrto Rican, etc.)	Blac	k, White, etc. White
21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		(Giv	edent's Usual Occu	during most of w	vorking	16b. Kind of Bu	siness/industry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire			- 36 -	
	lled w tygiei ther ti		17. Father's Name (First, Middle, Last)	8+	FO	rensic Ps		ST_ lame (First, Middle,	Self Em	
Maryland	d be f	o Be	Newton Cecil Clark					le McDowe		
کر	should and Men s marke umatic	၉	19a. Informant's Name/Relationship (Type				t and Number or	Rural Route Numbe	er, City or Town,	
	and 2 salth a n 27 is		Anne L. Clark/wife		116	26 Wolfsv	rille Ro	l. P.O. B	ox 398 S	mithsburg, Md
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1 Burial 2X Cremation 3 R 1 Donation 5 Other (Specify)	amount from State	cemetery, cr	position (Name of ematory or other pla rg Cremat	ory Jar	Date 1.16,2004		city or Town, State ourg, Maryland
Balti	permit. Departmit imports any inju		21 Synduce of Funeral Service License	711116				_	_	uneral Home Maryland 21742
÷			23a. Part1. Enter the disease, or compli- shock, or heart ailure. List only on	cations that caused the	death. Do not e	nter the mode of dy	ing, such as card	ac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	BRAINST		FARCT				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co		-				
Н	LAdiffici	,	Sequentially list conditions,	. — Due to (or as a co	A series aless					
	led Isit	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Coo ic (o. as a ci	orisaquerice ory.					
	al-trai	Examin	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
8760,	icate be executed physician and s the burial-transit	dlcal		l						
9	tificat og phy as th	a)								
Box	the attending place for use as the	Physiclan/M	in the past 12 months?	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	☐Ectopic pregnand	cy		23d. Date Mor	e of delivery nth Day Year
P.0	by the	Phy	9 ☐ Unknown  Part II. Other significant conditions cor		ot reculting in the	underhing cause g	wan in Part I	23a Did t	obacco use contr	ibute to the cause of death?
	v requires tha been signed should be del	b	Part II. Other significant conditions cor	induting to death but h	ot resulting in the	underlying cause g	iven in rait i.			3 ☐ Probably 4 ☑ Unknown
Records,	elaw has b	Completed						24a. Was auto perfo	psy ormed2 d	Vere autopsy findings available prior to completion of cause of leath?  ☐ Yes 2☐ No
Vital	yslcian: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					eath (Check only o	one)	
of V	Physician: this certific ral director,	ဥ	1 □ Yes 2 No	lospital: 1 Inpatient	2 ER/Outpati	ent 3L DOA		Home 5 ☐ Resi		
ion	fter	atlon:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yo	ear) 28b. Time Injury	W	ury at ork? □Yes 2□No	28d. Describe	how injury occurr	30
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Completely filled in by the to	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, Specify)	street, factory, office	3	28f. Location ( City or To		er or Rural Route Number,
	ne Hospil n 24 hour ne Funer pletely fill	edical		sician: To the best of mer: On the basis of ex and manner stated	amination and/or					nner as stated. and due to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	/		29c. Licer	nse number	1.6	29d. Date signed	(Month, Day, Year)
	48		Jellon Hu	up ph	15140	D	5618	3	1-1-	5-04
	8		30. Name and addless of person who co	propleted cause if deat	(Item 23a) (Typ	e. Print)	molis	Rd L	ha. 111 d	1 21742
90	St Regist	ate rar	31. Date filed (Month, Day, Year)	32-Registrar's	Signature	a Mil	1		l	•

State of Maryland / Department of Health and Mental Hygiene

			0		y	Cert	ificate o		R	eg. No.	UH	UJ	440
	Dhamisian	1. Decedent's Name (First, M.							2. Date of Deet Month	h Day	Year	3. Time o	
	Physician /Medical	Mabel	Eliza			Des	Shong	1	January	23, 20	04	9:25	P.M.
_	Examiner	4a Facility Neme (If not instit Julia Manor						Hagerst		4c. County Washi		1	
	Funeral Director	5. Social Security Number 212–38–5515	6. Sex 1 □ M 2		e (In yrs. last 78	birthday) Yrs.	If Under 1 Ye Months Day		Hrs. 8. Date of Birth Min. (Month, Dey. Sept. 28,	Year) 1925	Coun	elace <i>(State</i> etry) ISY1va	-
	pue *	Usuel Residence of Decedent 10a. State 10b. Co.			10c. City, T	own or Loca	ation				1	Od. Inside C	City Limits
	Maryle France		ington		Hage	rstown	1					1 🕅 Yes	s 2 No
	th with the	10e. Street and Number 248 N. Mulbe	rry St.				10f. Zip Code 21740		1	0g. Citizen of V		ntry?	
020	be filed within 72 hours after death with the Maryland stal Hyglane. d other than "natural", or terms 23e or 28e-f ahow event, the Medical Examiner must be notified at Be Completed by Funeral Director	11. Maritel Status  1  Never Married 2 3 Widowed 4 Divo	Ar	as Decedent I med Forces? Yes 2 7 Yes, Give A ear or Dates:		1	as Decedent of Yes, specify C		? (Specify Yes or No- uerto Rican, etc.)		k, White,		
21215-0020	n *natur Medical	15. Dece (Specify only hi	dent's Education ghest grade com	pleted) bliege (1-4or 5	1	6e. Decede (Give ki life. Do	nt's Usual Oct ind of work do O NOT use ref	cupation ne during most of ired)	working	16b. Kind of Bu	siness/Inc	dustry	
	2 should be filed within and Mantal Hygiane. ie marked other than eumatic event, the Mantal Comp	Elementary/Secondary (0-	2) (4	люде (1-4 <i>0</i> 1 5	(**)	Owner/	Operat			Restau			
ם	be file d oth event	17. Father's Neme (First, Mid							Name (First, Middle, I	Maiden Sumam	e)		
$\frac{8}{2}$	and Mantal he marked of cumatic eve	Paul David G		nin ti		10b Mailing	Address (Str		May Beal  Rural Route Number	City or Town	State Zir	(Code)	
Σ	s 1 and 2 should f Haalth and Mar item 27 ie marke other treumatic	Kay Evans/Dau		unt)					Hagerstown		21740		
ē,	Haalth Item 27 other tr	20a. Method of Disposition					tion (Name of atory or other)			20c. Location -	City or To	wn, State	
Ē	Pages nent of I ant: If ite ury or o	1 ☐ Burial 2 【Cremat 4 ☐ Donation 5 ☐ Othe		al from State			Crema		1/26/2004	Smiths	urg,	MD	
Baltimore, Maryland	permit. Pages Department of Important: If it eny injury or one	21. Signature of Funeral Sen	-			22.	Name and Add	dress of Facility	Rest Haven	Funera	1 Ch	ape1	
_	70 F • a	> S. Wark	Sun	)		160	1 Penn	sylvania	Ave. Hage	rstown,	MD		
	Physician	23a. Part1. Enter the disease shock, or heart failure.	e, or complication List only one cau	is that caused ise on each lir	I the death. [ ne.	Do not enter	the mode of o	lying, such as care	diac or respiratory arr	est,	1	Approxima Interval Be Onset and	etween
	/Medical Examinér	Immediate Cause (Final disease or condition	e	LUN	16 (	AN	CER				1	61	1
	SETTINE	resulting in deeth)		-	Due to (or es						1		
	outed ransit	Sequentially list conditions	b. —		Due to (or es	s e consequ	ence of):						
Š,	ficate be axecuted physician and its the burial-transit edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c										
09/89 X	2 2 2	resulting in death) Last	L d		Due to (or as	a conseque	ence of):						
ĝ	attandir I for use												
j.	nat tha daath ce d by tha attandii etached for use Physician/	Pert II. Other significant con	ditions contributi	ng to death bu	ut not resultir	ig in the und	lerlying cause	given in Part I.		ıbaccousecor es 2⊡No		othe cause bably 4□	
ς, J									_		_		
ital Records,	The law requiras that tha death ce cata has been signed by the attendi page 2 should be detached for use Completed by Physician/								24a. Was e perform		coi	ere eutopsy ailable prior mpletion of deeth?	to
Ĭ	hysician: The law his certificata has buildirector, paga 2 s								1 □ Ye	es 2XINo	10	Yes 2	□ No
<u> </u>	clan: sertific ector,	25. Was case referred to me- examiner?	dical Hospita	al·				Out .	Death (Check only on				
5	Physician: r this certific oral director,	1 Yes 2 No 27. Manner of Deeth		1 ☐ Inpatie a. Date of Injui		Outpatient b. Time of	3LI DUA	ijury at Vork?	g Home 5 Reside			y)	
0	oding tth. :: After a fune	1 Naturel 5 Pe		(Month, De)	Year)	Injury		Vork? □Yes 2□No					
DIVISION	ital or Attending P its after death. Its Directors After t led in by the funers Certification:	3 Suicide 6 Co 4 Homicide de	uld not be termined 286	e. Place of Inju- building, etc	ury - At home c. (Specify)	e, farm, stree	et, factory, office	00	28f. Location (St City or Town		er or Rura	il Route Nut	m <i>ber</i> ,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dimension of the funeral dimension of the funeral dimension. To the funeral dimension	29a. Certifier 1 Certifier (Check only one)	cal Examiner: O	To the best of the basis of and manner sta	examination	dge, death of end/or inve	occurred at the estigation, in m	time, date and pl y opinion, death o	ace, and due to the ca	ause(s) and ma ate and place, a	nner as si and due to	tated.	(s)
	within To the comple	29b. Signature and title of ce					29c. Lice	ense number	2	9d. Date signed	(Month,	Day, Yeer)	
			m 46 6	=			P	5232	.3	0//26	104		
, whi	17	30. Name and eddress of per									1		
7		Khalid Wasee	earl _		ourt, ar's Signature		stown,	MD 217	40				
-	State Registrar	31. Date filed (Month, Pey, Y	26 2004	SZ. The gratie	in Signature	4. Ap	ati						

			1 - For State Registrar		Maryland /	Depa		of H	lealth a	and M	lental Hy	giene Reg. No.		li,	00	
	Physici	an	Decedent's Name (First, Middle,     Decedent's Name (First, M								2. Date of Do	Day	, 20č	ear	3. Time of 6:00	f Death P M
>	/Medic	al	Betty Lorraine		shar)		4b. City, To	awa or	Location	of Death	Januar	-	County of		0.00	
	Examir	er	4a. Fecility Name (If not institution,	give street and nutt	1Der)		Hager			OI Deall			ashin		1	
			705 Medway Road  5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1	Year	If Under		8. Date of Bi (Month, D				ce (State o	or Foreign
.1	Funeral Director		213-24-8878 Usual Residence of Decedent	1 ☐ M 2(X)F	76	Yrs.	Months	Days	Hours	Min.	07/14/	1927		Country		MD
	land ow		10a. State 10b. County		10c. City, To	own or Lo	cation							100	d. Inside C	ity Limits
	Many Fred	ţ	MD Washi	ngton	Hage	ersto	wn								1 ¥Yes	2 □ No
	r 28s	lrec	10e. Street and Number				10f. Zip C					-	zen of Wha	at Countr	y?	
	1h wit	aiD	705 Medway Road				2174	40				US.	A			
	dea	ner	11. Marital Status	12. Was Dece Armed For	ident Ever in U.S.	13.	Was Decede	nt of H	ispanic Or	igin? (Spo	ecify Yes or N Rican, etc.)	0-	14. Race - Black.	American White, et		
21215-0036	be filed within 72 hours after death with the Maryland that hygiene od other than "natural", or itams 23a or 28a-f show avent, the Midical Examinar must be maillist at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced		2 <b>X</b> No e		1 □ Yes 2		Specify:			Ì	Specify:			
5	72 h	etec	15. Decedent' (Specify only highes)	s Education t grade completed)	1	6a. Deced (Give	dent's Usual kind of work DO NOT use	Occupa done	ation during mos	st of work	ing	16b. Ki	nd of Busin	ness/Indu	stry	
121	vithin ne han	dm	Elementary/Secondary (0·12)	College (1	-4or 5+)	ure.							Ribb	on M	ıfα	
2	S should be filed within and Mental Hygiene is marked other than aumatic avent, the Manat	ပိ	17. Father's Name (First, Middle, L	asti			1112	spec	18. Moth	er's Name	First, Middle	. Maiden		OII II	ug.	
Maryland	Mental I Mental I arked of atic ave	Be c	William Ri		1v				De	lsie	Mae K	irby	,			
2	2 should and Men is marke surnatic	ြ	19a. Informant's Name/Relationsh			9b. Mailir	na Address (	Street			al Route Numi		r Town, St	ate, Zip C	Code)	
<b>≥</b>	and 2 sealth and 2 sealth and 27 is		Dixie Newhouse	/ Persona			-				t, Hage					
Baltimore,	t of He		20a. Method of Disposition 1   Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp		State ceme	etery, crei	sition (Name natory or oth n Ceme	er plac			Date 3/2004		ecation - Cit			
=	artmen ortant: injury		21. Signature of Funeral Service L		Mest				-		rald N					Home
B	permit. Departn Imports eny inju	N S	115		\$						et, Hag					
>	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	a	aused the death. [ach line.	mo	/	7	g, such as	cardiac	or respiratory a	arrest,		10	Approximal Interval Bet Onset and 2	tween Death
1.5	Januari Insit	Examiner	Sequentially list conditions, if any, leading to infilterine cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (	or as a consequen	ee of):					-					
,092	e be exect sician and e burial-tra	cai Exa	resulting in death) Last	Due to (	or as a consequen	ce of):										
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	come of pregnancy irth 2 Fetal de ant at time of death own	ath 3[	Ectopic pred Other (spec					2	23d. Date o Month			Year
	that the by deta	P.	Part II. Other significant condition			ging the u	nderlying car	use giv	en in Part	l. 🔍	23e. Did	tobacco u	ise contribi	ute lo the	cause of	death?
ds	uires tha signed I	d b	Chione	Cooline	tuck .	Mili	una	ezx	Dr	Herre	_ 15	Yes 2	□ No 3	☐ Probat	oly 4 🗆	Unknown
of Vital Records,	sician: The law require certificate has been si lirector, page 2 should I	Completed	Chronic /typest	ensin				0				psy ormed?	prio	or to comp th?	sy findings pletion of c	available ause of
a	Physician: The lithis certificate ha	e Co	25. Was case referred to medical						26 Plan	e of Door	1 ☐ Yes	2 (No	1 1 L	Yes 2	∐ No	
Ę	Physician: this certificanal director, it	o Be	examiner?	Hospital:	npatient 2 ER	Outpatier	nt 3 DOA	Oth	7.		me 5 es		G □Other	(Specify)		
	Phy this ald		27. Manner of Death		7	b. Time o	1000	c. Injur	y at	-	28d. Describe					
lon	nding Pith. :: After e funera	ig ig	1 ⊠Natural 5 ☐ Pending	9	m, Day Year)	Injury	м	Wor	K? Yes 2. ☐	No						
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Diractor: Atter completely filled in by the funer	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 28e. Flace	of Injury - At home ng, etc. (Specify)	, farm, str	reet, factory,	office			28f. Location City or To	(Street an wn, State		or Rural I	Route Num	nber,
	Hospits     24 hours     Funeral     etely filles	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical I	g Physician: To the Examiner: On the band man	best of my knowle asis of examination ner stated.	dge, deat and/or in	h occurred a vestigation, i	t the tir	ne, date a pinion, de	nd place, ath occurr	and due to the red at the time	cause(s) date and	and mann I place, and	er as stat d due to t	ted. he cause(s	s)
	To the within ? To the comple	Me	29b. Si mature and title of certifier	0			29c.	Licens	e number			29d. Dat	te signed (/	Month, Da	ay, Year)	

State Registrar 31. Date filed (Month, Day, Year)

JAN 21 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
G. F. Pura, 366 Mill Street, Hagerstown, MD 32 Registrar's Signature

29d. Date signed (Month, Day, Year)

Physic		Registrar  1. Decedent's Name (First, Middle, La:  Alan W		ıthit			2. Date of Deat Month January	Day Year	3. Time of Death 13:12
/Medi Examii		4a. Facility Name (If not institution, give			4b. City, To	own, or Location of Dea		4c. County of Dea	
		5001 Mercedes Bou				amp Spring		Prince	
Funeral Director		5. Social Security Number 6. S 578 78 8177 X	G.,	In yrs. last birthday) 6 Yrs.	If Under 1 Months	Year If Under 24 Hrs Days Hours Min		1957 Was	thplece (State or Foreignintry) hington DC
Mot in		10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limit
nd Mental Hygiene marked other than "natural" or items 23s or 28s-f show imatic event, the Medical Exeminar must be notified at	Director		George	Fort Was					1 ☐ Yes 2 XX
S or 2	Dire	10e. Street and Number 8219 Birdsong	Drive		10f. Zip C	20744		Og. Citizen of What Co United Sta	
ms 23	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decede	nt of Hispanic Origin? (S y Cuban, Mexican, Pue		14. Race - Ame Black, Whit	erican Indian,
ral", or Items 23s or 28s-f show Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:		1   Yes 2		,,	Specify:	Black
"natural", edical Exa	etec	15. Decedent's E (Specify only highest gra	lucation de completed)	(Give	dent's Usual kind of work DO NOT use	done during most of wo	orking	16b. Kind of Business	/Industry
the Ma	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2		el Ager			UNKNOW	N
l othe	Be C	17. Father's Name (First, Middle, Last,				18. Mother's Na	me (First, Middle, I		
narked	2	John Douthit	To a Octob	105 14-0	8 dd /		bon Hunte		7:- Codel
item 27 is marked other than "natur other traumatic event, the Medical		19a. Informant's Name/Relationship ( John Douthit (Bro		7		Street and Number or R song Drive			
item other		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name	of		20c. Location - City or	
ant: # ury or	П	1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specil		Lee Crema	tory .	Jan 25, 200	4	Clinton, M	aryland
Important: if item 27 is marked other than eny injury or other traumatic event, the Ma once.		21. Signature of Fureyal Service Little	10015			<sup>Address of Facility</sup> Le Iria Ferry			
sician edical miner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Meningitis	ne death. Do not en	ter the mode	of dying, such as cardia	ic or respiratory arm	est,	Approximate Interval Between Onset and Death
7	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):					
attending physician and for use as the burial-transit	ical Examiner	Cates (Disease of Injuly that initiated events resulting in death) Last	C. Due to (or as a o	consequence of);					
been signed by the attending pl should be detached for use as t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death 3	⊒Ectopic pre			23d. Date of de Month	livery Day Year
signed b	b	Part II. Other significant conditions of	contributing to death but	not resulting in the u	ınderlying ca	use given in Part I.		bacco use contribute to	the cause of death?
S S	Completed						24a. Was a autops perform	sy prior to med? death?	utopsy findings availab completion of cause o
certific	Be	25. Was case referred to medical examiner?	Hospital:			Othor	ath (Check only on		a carana
After this funeral di	ion; To	1 XYes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day )	28b. Time o		c. Injury at Work?		ow injury occurred	SCENE
Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e and Place of Injury	y - At home, farm, st (Specify)			281. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
Funeral ely fillec	ledical C	29a. Certifier 1 Cartifying Pl (Check only one) 2 Medicel Exer	nysician: To the best of miner: On the basis of e and manner state	xamination and/or in	th occurred a nvestigation, i	t the time, date and place in my opinion, death occ	e, and due to the caurred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
N O O	Me	29b. Signature and title of certifier			29c.	License number	2	9d. Date signed (Mon	th, Day, Year)
To the complet			ini			O.C.M.E.		January 23	2004
within 24 hours after death.  To the Funeral Director; After this certificate ha completely filled in by the funeral director, page		I hy h	present			0.C.M.E.		January 25	, 2004

04-00824 Arthur Doege **RJD** 

#### Please Type or Print in Black Indelible lnk Ensure All Copies Are Legible

State of Maryland  State Unpended Item#23a,27,Per ME,G828,2	/ Department of Health and N			
Registrar	'-'Centricate of Death	Reg. No.		
Decedent's Name (First, Middle, Last)		2. Date of Death		3
Arthur Gustay Doege		January 30,	20 <b>0</b> 4	2

	ı
Physician	ı
/Medical	ŀ
Examiner	ľ

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event. I'm Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Arthur Gustav Doege											Caria	ary	30,	2004	2017P.
4a	4a. Facility Name (If not institution, give street and number)						4b. City, 7	Town, o	r Location	of Death		4	4c. Count	y of Death	1
	18199 Oal	kland	Avenue				Vall	100	T 00				Saint	t Mar	v's
	Social Security Nu 52-32-192		6. Sex XXM 2□	7. Age	(In yrs. last b	,,	If Under Months		I Under Hours	24 Hrs. Min.	8. Date of (Month,	Birth Day, Yea	ır)	9. Birth	place (State or F
_	sual Residence of I				0.5						Ju1y	31,	1938	New	York
10	a. State	10b. County	/		10c. City, To	wn or Loca	ation							1	10d. Inside City
M	aryland	St. M	lary's		Valle	ey Le	e								1 ☐ Yes 2
	e. Street and Num						10f. Zip					10g. (		What Cou	ntry?
18 199 Oak 1 and Avenue 20692  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)											USA				
11	Marital Status     Never Marrie     Widowed 4		ried Armi	ed Forces? Yes 2 ☐ N es. Give			as Decede Yes, speci □ Yes 2		ispanic Or in, Mexicai Specify:	gin? (Spi n, Puerto	ecify Yes or Rican, etc.)	No-	Bla	ce - Americk, White, fy: Whit.	
Maryland St. Mary's Valley Lee  10e. Street and Number  18199 Oakland Avenue  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☒ Married   1 ☒ Yes, Specify Cut   1 ☐ Yes, Specify Cut   1 ☐ Yes  ☐ Yes, Specify Cut   1 ☐ Yes  ☐ Yes									ation		Ju.	16b.	Kind of B	lusiness/In	dustry
_	(Specification (Speci			e <i>ted)</i> ege (1-4or 5-	+)	(Give ki life. D	ind of worl O NOT us	rk done d se retired	during mos	t of work	ing				•
	,	, , , , , , ,		4		Test	Pilo	ot				US	Gove	ernme	nt
17	. Father's Name (F										e (First, Mide	dle, Maide	en Sumar	ne)	
	Arthur C		-						Erna	Loh	rmann				
	9a. Informant's Nar			•							al Route Nui				-
-	ary Heler		e/ Wife						Avenu						d 20692
20	a. Method of Dispo		3 ☐Removal	from State	20b. Place cemet	of Disposit ery, crema	tion (Nam atory or oti	ne of ther plac	e)		Date	20c.	Location	City or To	own, State
	` 4 □ Donation	5 Other (S	Specify)		Metrop					/2/20	04	A1e	xandr:	ia, Vi	rginia
2	1. Signature of Fuq	eral Service	Licensee			Mat	tting1	d Addres	s of Facili	r Fun	eral Ho				
lr d	nmediate Cause (Fisease or condition	t failufe. List Final	t only one cause	on each line	Θ.	not enter	the mode	x. 27 e of dyin	0, Leo g, such as	cardiac o	or respirator	arrest,	0		Approximate Interval Betwee Onset and Dea
Ind re	shock, or heart nmediate Cause (F	titallufe. List	ab	Iyperter Je to (or as a	the death. Doe e.	not enter herose of):	the mode	x. 27 e of dyin	0, Leo g, such as	cardiac o	or respirator	arrest,	0		Interval Between
ST CCC th	shock, or heart mediate Cause (F isease or condition sulting in death)  equentially list contant, leading to interest units, leading to interest units. Enter Underlause (Disease or at initiated events sulting in death) La	tradufe. List	a	Iyperter Le to (or as a Le to (or as a	e.  Dive Atlanta consequence a consequence a consequence of pregnancy	p not enter  Perose  a of):  a of):	the mode	x. 27 e of dyin	0, Leo	cardiac o	or respirator	arrest,	23d. Da	te of delive	Interval Betwee
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Ired CC Cth res	shock, or heart mediate Cause (F isease or condition soluting in death)  equentially list condition and the condition are listed to increase or in at initiated events sulting in death) Left Bb. Was decedent in the past 12 m 1   yes 2   yes 1   yes 2   yes 2   yes 2   which was decedent in the past 12 m 1   yes 2   yes 2   yes 2   which was a case referrence warmer?  10 Yes 2   yes 2   which was a case referrence warmer?  11 Yes 2   yes 2   which was a case referrence warmer?  12 Yes 2   which was a case referrence warmer?  13 Yes 2   which was a case referrence warmer?  14 Yes 2   which was a case referrence warmer?  15 Yes 2   which was a case referrence warmer?  16 Was case referrence warmer?  17 Yes 2   which was a case referrence warmer?  18 Was case referrence warmer was a case warmer?  19 Yes 2   which was a case warmer warm	pregnant nonths? No cant conditions of Pendin investif 6 Could determ	a	s, outcome of Live birth 2 Pregnant at the Unknown of to death but 1 Inpatien Date of Injury (Month, Day) Place of Injury (Month, Day)	e.  Dasive Atl a consequence a consequence a consequence by pregnancy by prediction of death at not resulting by year)  1 ER/O by year)  1 At home, f 1 (Specify)  1 my knowledgexamination a	herosc  o of):  o of):  in the und  outpatient  Time of Injury  farm, stree	ictopic pre- Other (spe- Jerlying ca	egnancy egrify)  ause give	26. Place	of Death	23e. Di 23e. Di 1[ 24a. W au 1 X Yes 1 (Check online 5 □ Re 28d. Describ	d tobacco	23d. Da Mc	onth  all prob  were auto prior to cor death?  To Specify red	eny Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Indings avan poletion of caus 2 \( \) \(

State Registrar LING

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31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 3 2004

			1 - For State Registrar	State of M	Maryland		artment rtificate			and Me	-	giene Reg. No.	GTI.	J. (50
	Physici	<b></b>	Decedent's Name (First, Middle, La     Jane Gr		,					1	2. Date of De Month	ath Day	Year	3. Time of Death
	/Media										Januar	y 23	2004	1:39 PM
	Examir	ner	4a. Fecility Name (If not institution, giv Washington Count				11 112	Town, or erst	Location of	of Death			ounty of Death Washing	ton
	Euroval		5. Social Security Number 6. S		Age (In yrs. lasi	t birthday)	If Under		If Under:	24 Hrs. ] 8	B. Date of Bin	1	_	ace (State or Foreign
	Funeral Director			1 ☐ M 2 🖾 F	_	Yrs.	Months	Days	Hours	Min.	B. Date of Bin (Month, Da ept. 1	7°192	3 Mar	ÿland
	p ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	oum or Lo	antina						14	0d. Inside City Limits
	faryla shov	ō	Maryland Washing	ton		gerst							[ ''	Ves 2 No
	the A	Director	10e. Street and Number				10f. Žip	Code				10g. Citize	n of What Coun	try?
	h with		70 East Avenue						21740	)		U	.S.A.	
36	s within 72 hours after death with the Maryland iten. iten. r than "natural", or items 23a or 28e-f show the Medical Exactinative Legidied at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marned  3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1	s? ⊠No		Was Deced f Yes, spec		spanic Origin, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No ican, etc.)		Race - Americ Black, White, o pecify: Wh	
Ş	2 hou	ted	15. Decedent's E	ducation		6a. Dece	dent's Usua	I Occupa	ition			16b. Kind	of Business/Inc	dustry
212-0036	within 7 iene.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	kind of wor DO NOT us	e retired,	uring most )	t of working	7			
7	filed wi Hygien sther th		0-12	3			nurse		40. 14-15	4- 11	(F:		spital	
and	e d la b	Be	17. Father's Name (First, Middle, Last	ge McClel	lan Hor	rnbak	er		18. Mothe		<i>First, Middl</i> e, alar Ai			
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Ma	and 2 salth a n 27 is		JoAnn Fore - dau	ghter		300	North	Pot	omac	Stre	et, Ha	gerst	own, Ma	ryland <sub>21740</sub>
altimore,	ges 1 and of He		20a. Method of Disposition 1 [25Burial 2 [] Cremation 3 [	Removal from Sta	com	e of Dispo etery, cren	sition (Nam natory or of	e of ther place	9)	Da Janua:		20c. Loca	tion - City or To	wn, State
Ě	Pages Iment of tant: If it jury or o		*4 ☐ Donation 5 ☐ Other (Special	(y)			1 Cem		У 2	28, 20	004			Maryland
ng	permit. Pages Department of Important: If it any injury or		21. Signature of Funeral Service Lice	tal		41		t Wi	1son	B1vd	., Hag	ersto	al Home wn, Mar	yland 21740
8760,	beath certificate be executed attending physician and for use as the burial-transit	dical Examiner	23a. Par1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	a. Due to (or ab. Due to (or ab. C.	as a consequent as a consequent as a consequent	ice of):							3	Approximate Interval Between Onset and Death
O. Box 6	0 0	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal de at time of death	ath 3	Ectopic pre Other (spe					230	d. Date of deliver Month	ry Day Year
ds, P	w requires that the been signed by the should be detache	b	Part II. Other significant conditions of Chronic Patrick			,		luse give	n in Part I.			obacco use		e cause of death?
Hecord	e law has b	Completed									24a. Was autop		24b. Were autop prior to com death?	osy findings available apletion of cause of
VII	ilcien: Th certificate rector, pag	a a	25. Was case referred to medical						26 Place	of Death /	1 ☐ Yes Check only o	2 No	1 🗆 Yes	2□ No
	dis	To B	examiner?	Hospital: 1 npa	tient 2 ER	/Outpatien	t 3 🗆 DO	A Othe					Other (Specify	)
VISION OF	Attending Ph c death. ector: After th by the funeral	ertification;	27. Manner of Death  1 In Natural 5 Pending 2 Accident Investigation	n	njury 28 Da <i>y Year)</i>	b. Time of Injury	M 28	Sc. Injury Work 1 🗆 Y	at ? ′es 2 □ N		d. Describe h	now injury o	ccurred	
		Certific	3 Suicide 6 Could not be determined	286. Place of	Injury - At home etc. (Specify)	, farm, str	eet, factory,	office		28	f. Location (S City or Tow		lumber or Rural	Route Number,
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edical	29a. Certifier 1 Certifying Ph (Check only 2 Madical Exam one)	nysician: To the be miner: On the basis and manner	of examination	dge, death and/or inv	occurred a restigation,	it the time in my op	e, date and inion, deat	d place, an th occurred	d due to the d I at the time,	cause(s) an date and pla	d manner as sta ace, and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	// ~			-	License		( , )			igned (Month, E	
	4		3 any Mon	ran, v	9)			101	104	U		01-2	24-0	7
140	, ,		30. Name and address of person who							[4]		2/7	40	
	Sta	ite	BAKRY COHEN 3	32. Redi	strar's Signature	)	) It 14	UCA	SION	N	MU	211	70	
	Registr	ar	JAN 26	2004	Elm B	1. 1	certe							

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			1 - For State Registrar	Otato of Mic		rtificate of		Reg.	E 0.00	
	Dhysis	-	1. Decedent's Name (First, Middle, Last,		11150			2. Date of Death	Day Year	3. Time of Death
1	Physici /Medio		13t11t		JLLER			Februar	200	
	Examir		4a. Fecility Name (If not institution, give				or Location of Death	A: \n.	4c. County of Dea	ith
	Funeral	-	THE JOHNS HOP  5. Social Security Number  6. Security Number	KINS He	(In yrs. last birthday)		MOR E	8. Date of Birth	9 Bir	rthplace (State or Foreign
	Funeral Director				57 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month Day, Ye 8-6-1946	er) Per	ountry) Onsylvania
	pu ,		Usual Residence of Decedent		100 City T					
	ahov	5	Pa. Tioga		Middlebu					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the h	rect	10e. Street and Number		hiddiebui	10f. Zip Code		10a.	Citizen of What Co	
	3a or	100	R.D.2 Box 110				6935			•
	death	ner		12. Was Decedent 8 Armed Forces?	Ever in U.S. 13.		dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	United St	erican Indian,
36	or He	by Funeral Director	1 Never Married 2 Married	1 ☐ Yes 2 🗖 N If Yes, Give 🛣	lo	1 ☐ Yes 2 ☑ No	Specify:	riican, etc.)	Black, Whit	
21215-0036	tited within 72 hours after death with the Maryland Hygiene. uther than "natural", or tlems 23a or 28a-f ahow inther than "natural" or trust be trotified at	q pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:		dent's Usual Occur	nation	166	. Kind of Business	nite
15	n na n na Nealic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed)  College (1-4or 5-	(Give	kind of work done DO NOT use retire	during most of work	ting	. Kind of Business	rindustry
212	filed withi Hygiene. other then ent, It a M	E O		)+		ol Teach	er	Fo	ducation	
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Maryland	2 should be and Mental Is marked o	1º	Clayton Cheesman	0.00			Velma			
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic avent, it a Medical Examinar must be untilied at		19a. Informant's Name/Relationship (Ty  John Fuller - Hu	isband		0.2 Box		al Route Number, Cit dlebury Ce		
re,	s 1 and 3 f Health item 27 other tra		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Place of Dispo			Date 20c.	Location - City or	Town, State
Baltimore,	8 = 5		15 Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Middlebur			2/6/2004	4iddlebur	cy Center, Pa
alti	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service License		223 2	2. Name and Addre	ss of Facility Tu	ssey-Moshe	er Funera	al Home, Ltd.
	20529		Homen OSa	ter	1	39 Main	Street	Wellsbor	o, Pa.	16901
VE.			Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused ne cause on each lin	θ.					Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	metas	tatic	lectal	49 en	ocarcin	oma	Unknown
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687	ficate p phys			d						
Вох	eath certific attending p	M/U	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome o		Ectopic pregnancy			23d. Date of del	livery
	e deat he att	Physician/Medi	in the past 12 months?	4☐Pregnant at t		Other (specify)			Month	Day Year
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Vital Records,	signe d be c	d by	Part II. Other significant conditions con	thouling to death bu	t not resulting in the o	ndenying cause giv	en in Parti.			the cause of death?
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Re	The lav	dwo						autopsy performed	prior to death?	completion of cause of
ital		BeC	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 ☐ I	¶o   1 ∐ Yes	2 No
of V	lis d	To	examiner? 1 Yes 2 No	lospital: 1 Thipatier		it 3□ DOA Cth	er: 4 Nursing Ho	me 5 Residence	6 ☐Other (Spec	cify)
o uc	ding Ph h. After th funeral	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Worl	k?	28d. Describe how in	jury occurred	
Division	Attending r death. ector: After by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, farm, str		Yes 2 □No	28f. Location (Street	and Number or Pu	iral Pouta Number
Div	al or A	Certification;	4 Homicide determined	building, etc.	(Specify)	odi, raciory, omos		City or Town, Sta	ite)	rai noute ivamber,
	Hospital		29a. Certifier 1 Certifying Phys	sician: To the best o	f my knowledge, death	occurred at the tin	ne, date and place,	and due to the cause	(s) and manner as	stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	fedical	one)	and manner stat	examination and/or in	vestigation, in my o	pinion, death occur	red at the time, date a	and place, and due	to the cause(s)
•	To To	Σ	29b. Signature and title of certifier	0		29c. Licensi			Date signed (Month	
7	2-4		WAY IN	Palatad	oth (ltor co-) T	P1 000	6645	િ નિશ	ruary	1, 2004
	01		30. Name and address of person who co	PKINS H	CSPTTAI	HOO NOW	THE	6 STREE	IDE, MI	0 5 00 2128-
	Sta		31. Date filed (Month, Day, Year)	32. Hegistra	rs Signature			C - ILLEE	Our Clar W	ore where
1	Registr	ar	FFR - 6 20	na 📗	20 4	Control -				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Lawrence Elwood GARLING, SR. January 24, 2004 (a:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 18045 Lappans Road Fairplay Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 4,1928 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land **Funeral** 1⊠M 2□ F 75 Yrs. Director 215-20-8098 Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Macical Examinar must be notified at Maryland Washington Fairplay Director 1 ☐ Yes 2 ◯XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18045 Lappans Road 21733 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give 1946— Year or Dates: 1947 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 □ Never Married 20% Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) owner and operator transmissions permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: if Item 27 is marked othe any injury or other traumatic event, spice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milton Lawrence Garling ပ္ Mary Elizabeth Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Garling - wife 18045 Lappans Road, Fairplay, Maryland 21733 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State January 28, 2004 4 Donation 5 Other (Specify) Cedar Lawn Memorjalk Hagerstown, Maryland 21. Signature of Funeral Service Licenses Minnich Funeral Home 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 tred L. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a APENOCHACINOMA OF PROSTATE YGARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death Month Dav Year 5 Other (specify) P.O. å. detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ate has been signi page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) PIS 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D01040 54 141 01-27-2004 ary 30. Name and person who completed cause of death (Item 23a) (Type, Print) RAKKY E. ANTHETAM ST H4GERSTOWN COKET ND 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year Christy Lynn HINES 2004 anvary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 21 F 213-68-7041 Director 45 April 10 1958 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location iral, or itams 23a or 28a-f ahow Examiner must be notified at 10d. Inside City Limits Directo XXYes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 508 South Cannon Avenue 21740 Funeral U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: if item 27 is marked other than 'natural', or itams 23 uny or other traumatic event, it a "Accided Examine ruan. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes X ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Gas Station 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ Bill Sours Janet Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hines - Husband 508 South Cannon Ave. Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of the Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Manor Gemetery 1/24/04 Tilghmanton, Maryland permit. 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) Physician months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Year 4☐Pregnant at time of death Day 5 Other (specify) detached 9 Unknown been signed t should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ◯ No Inpatient 2 EN/Outpatient 3 DOA 2 this ate of Injury (Month, Day Year) 27. Manper of Death Certification: 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 2 Accident Hospital or Attendi 24 hours after death. Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

23 2004

			1 - For State Registrar		State of Ma	aryland	-	artment <i>rtificate</i>			Mental Hy	ygier Reg. N		10101
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	Physici		VIRGIL LY	NN I	KEPHART					9	Month	~ [	Dey Yeer	
	/Medic Examir		4a. Fecility Name (If not ins					4b. City, T	own, or Loca	ition of Death		2	c. County of De	+
	naviiii		WASHINGTON	COUNT	Y HOSPITAL				HAGE	RSTOWN			WAS	SHINGTON
1	Funeral		5. Social Security Number	6. S	ex 7. Ag	e (In yrs. la	st birthday)	tf Under 1 Months		nder 24 Hrs.	8. Date of B	irth		irthplace (State or Foreign Country)
Ü	Director		218-34-4029	1.	<b>⊠</b> M 2□F	67	Yrs.	Workins	Days	141111.	APRIL 2	20,	1936	MARYLAND
	p ,	į.	Usual Residence of Deced			10a City	Town or Lo	antina .						10d Inside City Limite
	aryla shov	_				TOC. City,	TOWN OF EG	cation						10d. Inside City Limits 1 X Yes 2 □ No
	the Marylar 28a-f show notified at	ecto		WASHII	NGTON			101 71 6	BOONS.	BORO		10- 6	2141	
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	ss 23	erai	116 SOUTH M	AIN S.	12. Was Decedent	Ever in 11 S	12.1	Mac Decede		713	acifu Vae or N	lo-	14. Race - Am	S.A.
	toes 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Exaciner must be rediffied at	Funeral Director	11. Marital Status 1 □ Never Married 2 2	Married D	Armed Forces?		. 13.	I Yes, specif	y Cuban, Me	xican, Puerto	pecify Yes or No Rican, etc.)	0-	Btack, Wh	
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Via	should be nd Mental marked o	To I	ELMER ALBER	T KEPI	HART						E KEADI		·	
Maryland	2 sho and is m		19a. Informant's Name/Re			1						-	or Town, State,	Zip Code)
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ore	Pages 1 nent of H int: If its		20a. Method of Disposition 1   Burial 2 □ Crem	ation 3 🗆	Removat from State	cer	netery, cren	sition (Name natory or oth	er place)		Date	20c.	Location - City o	r Town, State
Baltimore,	ury Birt		`4 □Donation 5 □Ot		<u> </u>	BOO		O CEME			/2004			MARYLAND
3a	permit. Departrimports any inj		21. Signature of Juneral S	ervice Licen	Paul	M. De		Name and		LIOME			ational	
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1.0			23a. Part . Enter the disea shock, or heart failure	Est only	one cause on each lir	ne.			-		1			Approximate Interval Between Onset and Death
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	pet nsit	nin	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ໍ ⊀			,	PATH	· Ca					MONTHS.
	xecu and al-trai	xar	that initiated events resulting in death) Last		Due to (or as			PATILI	7					MOULES
68760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	edicai Examiner		·	d									
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Вох	eath certifi attending I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregna	int	23c. tf yes, outcome	of pregnan							23d. Date of de	alivery
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	res tha signed be det	y P	Part II. Other significant co	onditions co	ontributing to death be	ut not result	ting in the u	nderlying cau	ise given in f	Part I.	23e. Did	tobacco	use contribute	to the cause of death?
rd	w require been sig should b	ed									1 🗆	Yes	2 □ No 3 □ P	robably 4 Unknown
သွ	has bei	Completed by									24a. Wa:	s an	24b. Were a	utopsy findings available completion of cause of
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<u>+</u>	hysic his ce I dire	To	1 ☐ Yes 2 No		Hospital: 1 X Inpatie	nt 2 E	R/Outpatien	t 3 DOA	Other: 4[	☐ Nursing Ho	me 5 Res	idence	6 □Other (Spe	ecify)
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Sio	Attending ir death. ector: Alter by the fune	cati	2 Accident	nvestigation Could not be	.			М	1 Tes	2 No				
Division	or Att	Certification:		determined	28e. Ptace of Inju- building, etc	ury - At horr c. (Specify)	ne, farm, str	eet, factory,	office		28f. Location City or To			Rura / Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	29a. Certifier 1 2 Ce (Check only 2 Me	odicet Exem	ysician: To the best on hiner: On the basis of and manner sta	examination	ledge, death on and/or inv	n occurred at vestigation, i	the time, da my opinion	te and place, , death occur	and due to the red at the time	cause( , date a	s) and manner a nd place, and du	s stated. e to the cause(s)
	o the ithin 2 o the omple	Mec	29b. Signature and title of	certifier	and manner sta	illed.		29c.	License num	ber		29d. D	ate signed (Mon	th, Dav, Year)
	+ 3 F 8			MO.	2017 1	NN			111	1511		-	AN I	2 20011
	108		30. Name and address of p	erson who	completed cause of d	eath (Item 3	23a) (Tvne	Print)	041	0361		J	117) 1	1,2004
	*1		& HAZALA	QAD		4	PAN 1	lo	M	BOON	SBOLD	1	MD 21	713.
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	Registr		JA	N 21	2004 Zens	was .	D. Ja	Joseph	•					

State of Maryland / Department of Health and Mental Hygiene "Amend Item#5,8perFH,Item#24aperPHYG8282/12/04Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month 3. Time of Death **Physician** 02 12:05 AN 4nsmar 3-2014 ran /Medical 4b. City, Town, or Location of Death 4a Facility Nam VII not institution, give street and number, 4c. County of Death Examiner Binnie ar Ford Aberdeen If Under 24 Hrs. 8. Date of Birth 7/5/1935 9. Birthplace (State or Foreign Min. Min. 1997) 7. Age (In yrs. last birthday) Yrs. If Under 1 Year **Funeral** Days Months 1□M 2MF 227-44-7643 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or frame 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2□No Aberdeen Funeral Director Marford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 Donni 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1□ Yes 2Z No Baltimore, Maryland 21215-0020 Specify. Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) ouse wife 12 Home th end Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 end 2 should be Depertment of Heelth end Mental Important: If item 27 is marked of any injury or other traumatic ev Burnette Melly reat harles Suc 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robin Stocz 195 20b. Place of Disposition (Name of cemetery, crematory or other place) Aberdeen Ma 21001
Date 20c. Lection - City or Town, State -daughter 20a. Method of Disposition

1 N Burial 2 □ Cremation 3 Removal from State Baker Cemetery 2-5-204 Aberdeen 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee dress of Fich ras 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical STAGE IV NOW SMALL CELL WNG CANCER 9 MONTH Examiner Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 02-03-01 evenacion MD D45530 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21014 SOUTH SUITE 200, ATWOOD 32. Registrar's Signature 31. Date filed (Month, Day, Year), State

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene

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			North Hampt								Freder				ede	rick		
	Funeral Director		5. Social Security Number 159–52–0607	6. Se	× □ M 2□¥F	7. Age 8	(In yrs. lest	Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	8. Date of Birtl (Month, Day Aug. 13	h y, Year) 3,191	.5	9. Birthp Coun Penns	lace (Stete try) sy1var	or Foreign nia
	and **		Usuel Residence of Decedent 10a. State 10b. Cour	ity		Ţ.	10c. City, To	own or Loc	cation							10	Od. Inside C	City Limits
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Maryland 21215-0020	72 hours efter death with the Maryland natural", or Nema 23a or 28a-f show dical Examiner must be notified at	by Funerai	11. Marital Status 1 ☐ Never Merried 2 ☐ M 3 🌂 Widowed 4 ☐ Divorce		12. Was Dec Armed Fo 1  Yes If Yes, Gir Year or D	orces? 2 ZNo ve			Vas Deced Yes, spec		ispenic Origir an, Mexican, F Specify:	n? (Spec Puerto R	cify Yes or No- lican, etc.)			e - America k, White, e : Whi	etc.	
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2	should tend Ment	٩	19a. Informant's Name/Relation		une Print)		1	9h Mailin	o Address	(Street			Route Numbe	r City or	Tourn	State 7in	Code)	
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e,	f Hea f Hea other		20e. Method of Disposition	,			20b. Place ceme					WOO	Date			City or To	wn, State	
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	Physician /Medical Examiner	er	Immediate Ceuse (Final diseese or condition resulting in death)	,	ATHOR		LSP 07 ue to (or as			OVA	SCULA	er 1	DISEA	sE	_	-	Onset and	
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Division	al or Atte s efter de il Directo ed in by th	Certification:	3 Suicide 6 Coul 4 Homicide dete	d not be mined	28e. Plece buildii	of Injury ng, etc. (	- At home, (Specify)	farm, stre	et, factory	, office		28	of. Location (Since City or Town	treet and n, State)	/ Numbe	er or Rural	Route Nun	nber,
	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer	edicai (	29a. Certifier 1 Certify (Check only one)	ing Phys Il Exami	olclan: To the nar: On the be and men	esis of ex	kaminetion e	ge, death and/or inve	occurred a estigation,	at the tim	e, date end p pinion, death o	occurred	d due to the c l et the time, d	euse(s) a late and p	and mar place, a	ner as sta nd due to	ated. the cause(	s)
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J.	B	-0.2	30. Name end eddress of personald Miller	P	.O.Box	210	Mt.	Airy,	, MD	217								
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Nellie Belle MALASHUK January 23, 2004 9:10a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beverly Health Care Hagerstown Washington | House 1 Year | House 24 Hrs. | 8. Date of Birth (Month, Day, Year Nov. 2, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 90 Yrs. 215-56-3229 Director 1913 North Carolina Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rthan "natural", or items 23e or 28e-f shov the Medical Extenine must be notified at Maryland Washington Hagerstown 1X Yes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 55 East Washington Street 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No white Specify: ≥ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker 0 - 7her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental Hent: if item 27 is marked out jury or other treumatic aven Be John McCotter Gertrude Delamar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Avey - daughter 11827 Peacock Trail, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gettyshurg National
Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State January 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page:
Department o
Important: If
any injury or
once. Gettysburg, Pennsylvania ' 4 ☐ Donation 5 ☐ Other (Specify) 27, 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland<sub>21740</sub> Fred Lusta 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate set and Death Immediate Cause (Final disease or condition resulting in death) **Physician** aspiration Moniti neuma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, isating to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner physician and s the burial-transit Due to (or as a consequence of): Physician/Medical attending pl IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b lirector, page 2 s autopsy performed? Yes 2 2 No 1 ☐ Yes Division of Vital tha Hospital or Attanding Physicien: : After this certification tuneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 K No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation Natural after death. 1 TYes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28365 m 23a) (Type, Print) Stral Hagestown MD21740 368 nuil 31. Date filed (Month 32. Registrar's Signature

State Registrar

Disus	ian	1 - State Registrar WCHD / SH 0 1. Decedent's Name (First, Middle,	Last)	per Dr	00711	incate of t	Dealii		2. Date of D			3. Time of Death
Physic /Med		Cora Isabella N	IELBACK						Month	Day	Year	11:30 A
Exam	ner	4a. Facility Name (If not institution,		er)	4	4b. City, Town, or		Death		4c. Cou	nty of Death	
		233 Winter Stre		Age (In yrs. last b	iethda)	Hage:	rstown	∐rc	0.0	W	ashin	
Funera Director		216-22-8453 Usual Residence of Decedent	1 M 2 🖾 F	75		Months Days		Min.	March	rth a <i>y, Year)</i> 2, 192	9. Birth Cou	place (State or Foreig intry) cyland
/land		10a. State 10b. County		10c. City, Tov	wn or Local	tion						10d. Inside City Limit
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s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notitled at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 I If Yes, Give Year or Date:	s? 4No	_	s Decedent of Hi es, specify Cuba Yes 2 2 No	spanic Origin n, Mexican, P Specify:	? (Spec uerto P	cify Yes or No Rican, etc.)		ace - Ameri lack, White, cify: Wh	etc.
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s 1 and 2 if Health item 27 i		Debra Hahn - dau	ghter	120	810	London (	t., Fr	ede	rick,			
m O		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3			ry, cremate	ory or other place	1 1/	22/2	004	20c. Location	- City or To	own, State
F. Francis		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lie		Mt.Zio	1	urch Cem		22/		Cearfos		
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The law requires that the ate has been signed by the page 2 should be detache	5	Part II. Other significant conditions	contributing to death	but not resulting in	the under	rlying cause giver	in Part I.					e cause of death?
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HU		30. Name and address of person who	. PASITA	MD	Type, Print							21740
Sta Registr		31. Date filed (Month, Day, Year)  JAN 22	32. Registi	rar's Signature	Ans	BI						21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:45 a.<sup>™</sup> Louise Virginia MURITZ 21, January 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Beverly Health Care Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 15,1917 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 🖾 F Mary land 219-20-2740 86 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a. State r than "neturel", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21742 12010 Mayfair Avenue USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: white þ 3 

Widowed 4 

Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than "ne any injury or other treumatic event, Its Mental 2006. Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gertrude Trumpower C. Lloyd Hull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11803 Patrick Road, Hagerstown, Md. 21742 Robert E. Muritz - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Rose Hill Cemetery 1/23/04 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses U 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Altrewooder mins /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit certificate be executed Due to (or as a consequence of) Physiclan/Medlcai as the the attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year į in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 3 Probably 4 MUnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. To the Hospitel or Attendi within 24 hours after death. To the Funerel Director; A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Marian D28/365 1-21-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) × /x Stral- Nagerstonn 19021740 368 mills

Registrar

State

Maryland 21215-0036

Baltimore,

Box 68760,

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Records,

Division of Vital

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month **NMN** 0450 AM Hege Martin lanuary 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 2, 1915 **Funeral**  Birthplace (State or Foreign Country) 1 XM 2 ☐ F Months 216-30-3637 Director 88 May Washington Co., MD Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location or 28a-f show 10d Inside City Limits traumatic event, the Medical Exertiner must be notified at Funeral Director 1 Yes 2 No MD Washington Clear Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 14439-A Hicksville Road "natural", or Items 23a 21722 death 1 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: δ Specify: White 3 Nidowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) farmer dairy farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ages 1 and 2 should by of Health and Menta : If item 27 is marked Eli H. Martin Susan Hege 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **1**4439 Hicksville Road Clear Spring MD 21722 Leon E. Martin other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages ' Mt Olive Mennonite Church Cemetery PBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If injury or 4 ☐ Donation 5 ☐ Other (Specify) 02/04/04 Mauransville MD 21767 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Miller-Bowersox Funeral Home any in Edritte 521 S. Washington Street Greencastle PA 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebral avel disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner eumo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): inding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed tailur enal resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68769 Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 0 4☐ Pregnant at time of death Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown ate has page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Lo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury after death. 2 Accident 1 ☐ Yes 2 ☐ No completely filled in by the t 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funaral I To the Hospital 29a Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060396 1/30/04 30\_Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, Maryland 1126 Opal Court Murshec 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2084 Registrar

**ORIGINAL** 

		1 - State Registrar	State of Maryla		artment of rtificate of			giene Reg. No.	2004	0346	
		1. Decedent's Name (First, Middle, Last)	, 0				2. Date of De	ath Day	Year	3. Time of Death	
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/Medi Examin		4a. Fecility Name (If not institution, give s.	treet and number)		4b. City, Town,	or Location of Deat		4c. (	County of Death		
ZX		Washington County	Hospital		Hager	stown		W	ashingto	on	
Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Yea Months Days	r If Under 24 Hrs				lace (State or Foreign	
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<u> </u>		Usual Residence of Decedent							Τ.		
rylar		10a. State 10b. County	10c. (	City, Town or Lo	cation				1	0d. Inside City Limit: 1 ☐ Yes 2 No.	
B Ma	Director	Maryland Washingt	on	Smithsl	ourg						
or 28	lire	10e. Street and Number			10f. Zip Code			10g. Citiz	ten of What Cour	ntry?	
death with the Maryland ms 23a or 28a-f show		12019 Bayer Drive			21	783		U.	S.A.		
dea dea	Funerai	11. Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 1	<ol> <li>Race - America</li> <li>Black, White,</li> </ol>		
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permit. Pages 1 am Department of Heali Important: If item 2 eny injury or other once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re	Į.	cemetery, crei	osition (Name of matory or other p	lace)	Date	20c. Loc	cation - City or To	own, State	
Pag nent ant: I		*4 □Donation 5 □ Other (Specify)		ose Hil	1 Cemete	ry 1/28	3/04	Hag	erstown	, Marylan	
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Physician /Medical Examiner page 1820 per pa		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):									
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To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	vicien: To the best of my liner: On the basis of exam and manner stated.	nowledge, deat ination and/or in	th occurred at the livestigation, in my	time, date and plac y opinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)	
To the compound of	Σ	29b. Signature and title certifier	+		29c. Lice	nse number		29d. Date	signed (Month,	Day, Year)	
		1 Canlor	_		1	5031.2		1-	26-06	+	
XVD		30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type,	Print)	Blod.	Souths	ellra	md	21783	
Si	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	Cart .			1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 1540 P M Wallace Walter Perkins January 25 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Cecil Union Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) Social Security Number **Funeral** 1KIM 2□ F Director March 29, 1926 Delaware 221-14-9554 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral, or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Cecil Elkton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21921 United States 233 Sycamore Road Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene.
sent of Health and Mental Hygiene.
sent if item 27 is marked other than "natural", or Itams 23, any or other traunralic event, it a Medical Exertinal round. Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 1 ⊠Yes 2 □ No If Yes, Give War II Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: þ White 3XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Maintenance Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Perkins Mary Fitzgerald 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wallace W. Perkins, II/Son 107 North Tartan Drive, Elkton, Maryland 21921 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Gilpin Manor January 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 28, 2004 Elkton, Maryland Memorial Park 21. Signature of uneral Service Lices 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part 1. Epfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List day one cause on each line. Immediate Cause (Final disease or condition resulting in death) POX Physician /Medical Due to (or as a consequence of) ENA PAILURE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ROSEPSIS burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CANCER LIVER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3□ DOA Atter this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending death. t Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeret Direct 4 Homicide 🖄 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Suggar, M.D. JANUARY, 26,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Thomas M. Duggan,

31. Date filed (Month, Day, Year)

21215-0036

Baltimore, Maryland

Box 68760

P.0.

Division of Vital Records,

M.D., 207 North Street, Elkton, Maryland 21921

32. Registrar's Signature

2004

			For State Registrar	State of M		/ Depa	artmer	nt of H			ental Hyg		004	03460
	Physici /Medio	cal	Decedent's Name (First, Middle, La     Rosalie Marie S     4a. Facility Name (If not institution, give	pitzer			4b. City	, Town, or	Location of	Ţ	2. Date of Deal Month	Day V 26	Year 2004 unty of Death	3. Time of Death
	Funeral Director		Washington County Hospital Hagerstow  5. Social Security Number  6. Sex 1 M 20 F 62 Yrs.  Hagerstow  6. Nex 1 M 20 F 62 Yrs.  Hours								Date of Birth (Month, Day, arch 6	Year)	9. Birth	on County place (State or Foreign inty) yland
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Z I Z I D-UUSO ed within 72 hours after giene rer then "netural", or Ite rer then "medical Exercities	ours after death viral; or Items 234	by Funeral	7759 Fairplay Roa  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?			21713 Was Decedent of Hispanic Origin? (Specify Yes of the Specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☐ No Specify:					14.	ican Indian, etc. CE	
	e filed within 72 ha al Hygiene. I other then "netu vent, the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 10  17. Father's Name (First, Middle, Last	College (1-4or	dent's Usual Occupation kind of work done during most of working DO NOT use retired)  Driverter Operator  18. Mother's Name (First, Mide					Label Mfg. CO.				
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Saitimore, n	permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra		Charles Clinton Spitzer.Sr. Husband 7759 Fairplay Road, Boonsboro, Maryland  20a. Method of Disposition  1XD Burial 2 Cremation 3 Removal from State  14 Donation 5 Other (Specify)  20b. Place of Disposition (Name of commetery, crematory or other place)  Cedar Lawn Mem. Park  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Douglas A. Fiery Funeral Service Licensee										n, Maryland	
ספו	permit. Depart Import any inj		21. Signature of Funeral Service Licel  23a. Part1. Enter the disk se, or comshock, or heart fail re. List only	A J	d the heath.	13	31 E	aster	n Blv	J. N.	. Hager	stown	y Fune , Mary	eral Home land 21742 Approximate Interval Between
,00,	Physician Amedical Examiner  Be executed Examiner  Be prijal-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequer	nce of):	stati	ic Ad	lenocar	CINE	ma ex	2 Cold	No.	Onset and Death
ם :	w requires that the death certaicate been signed by the attending phys should be detached for use as the	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	Ectopic pregnancy					23d. Date of delivery Month Day Year					
Vital Records, P.	The law requires that the site has been signed by the sage 2 should be detached.	ompleted by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								1 ☐ Ye	tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown s an 24b. Were autopsy findings available		
		Be Com	25. Was case referred to medical examiner?	26. Place of Death (Chi						autopsy prior to completion of cause of death?  1 □ Yes 2 □ No □ □ Yes 2 □ No  Check only one)				
A to not	i o the hospital of Attending Physician: within 24 hours after death To the Funeral Director: After this certifics completely filled in by the funeral director.	은	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	ent 2 ER	VOutpatien Bb. Time of Injury		28c. Injury Work	4 🗆 IAUI 2	280		dence 6 Other (Specify) how injury occurred		
DIVISION	ital or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					281	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
:	the Hosp hin 24 hou the Fune hpletely fil	Medical	(Check only 2 Medical Exar	ysician: To the best niner: On the basis o and manner st	f examination	edge, death n and/or inv	estigation	n, in my op	pinion, death	place, and occurred	at the time, da	ate and pla	ce, and due to	o the cause(s)
•		M	29b. Signature and title of certifier  Somir Khe	isi MD			29	c. License		06			gned (Month,	2004
żX.	Ψ		30. Name and address of person who	21 , 1130	OPA	L Co	urt		A GERS	STOW	n Me	) 21	740	
	Sta Registi		31. Date filed (Month, Day, Year)  JAN 27	32. Registr	rar's Signatur	e 1. S	oute	)						

Registrar DHMH 17 Rev 1/2001

				1 - For State Registrar	State of Marylar		ırımen <i>tificat</i> e			мептаг	-	. No.	) ( \ \		
				Decedent's Name (First, Middle, Last)						2. Date of Month		Day.	Year	3. Time of Death	
		Physici /Medic		WAYNE MELVIN	SMITH					JANU		24	2004	0010 AM	
		Examin		4a. Facility Name (If not institution, give			4b. City,		Location of De				ty of Death		
				WASHINGTON COUNTY  5. Social Security Number 6. Sex		last hirthday)	If Under		GERSTON If Under 24 H	IS. P. Date o	f Birth		ASHING		
	*	Funeral Director			IM 2□F 86	Yrs.	Months	Days	Hours Mi		$3, \frac{Day}{3}$	1917	Count VI	ace (State or Foreign ry) RGINIA	
	0	/land		10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10	d. Inside City Limits	
	M	ar death with the Marylan teme 23a or 28a-f show at tribal be tedified at	ctor	MARYLAND WASHING	ION				GAPLAN	D	1			1 □Yes 2X No	
	i t	with th	Director	10e. Street and Number			10f. Zip		01 770		100	. Citizen o	f What Count		
	4	eath ve 234	Funeral	3112 KAETZEL ROAD  11. Marital Status	12. Was Decedent Ever in U	.S. 13. \	Was Deced		21779	(Specify Yes o	r No-	U.S.			
	336	at o	by Fun	1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 ⊠Yes 2 □ No 194 If Yes, Give Year or Oates: 194	+3-	f Yes, spec I □ Yes 2		spanic Origin? n, Mexican, Pu Specify:	erto Rican, etc	.)	Spec	ack, White, e	White, etc. WHITE	
	15-0036	n 72 hours natural', adical Ex	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced	lent's Usua kind of woi DO NOT us	rk done a	uring most of w	orking	16	b. Kind of	Business/Ind	ustry	
بيلا	Maryland 2121	2 should be filed within and Mental Hygiene.  Is marked other than eumatic event, Italian	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	mo. 2	WEL	CA THE IN	<b>'</b>		M	ETAL	FABRIC	CATION	
A *	1d 2	tal Hygid other	Be C	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Mi		-			
3	Vlar	2 should be t and Mental h le marked of eumatic eve	ToE	EZRA CALEB SMITH					VERNA	V. SMI	TH				
E	Aar			19a. Informant's Name/Relationship (Ty					nd Number or						
WITH, WAYNE		1 and Healt Healt Healt ther		MEDZA A. SMITH/SP	20b. F	Place of Dispo	sition (Nan	ne of	OAD, GA	PLAND,	-		2177 1 - City or Tov		
/	nor			1 XBurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	A C A NTTP			1	27/200/	' PO	uprpc		MARYLAND	
	Baltimore,	그 돈 뿐 글		21. Signature of Fune of Service Hims		22	. Name an	d Addres	s of Facility	7606			onal P		
	Ö	Deparent Permit		De de la la la la la la la la la la la la la	elly A. Zimme	rman B	AST F	UNER	AL HOME					21713	
		= = 11		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat	h. Do not ent	er the mode	e of dying	, such as card					Approximate Interval Between	
		Physician		Immediate Cause (Final disease or condition	myeron	dies .	nfa	nut.	an					Onset and Death	
		/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	C							Ihain	
			er	Sequentially list conditions,	. Due to (or as a nonsec	uanea of):								7	
	9	d d ansit	Examiner	Sequentially list conditions, if any, I sawing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
	ó	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):									
		0 2 0	lical		1										
	x 68	ding p	/Mec	IF FEMALE:	3c. If yes, outcome of pregna	ancy						004.5			
	Вох	death certificate b attending physic d for use as the b	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	death 3	Ectopic pro Other (sp				_		ate of deliver donth	y Day Year	
	P.O.	that the de led by the delached	hys	9 Unknown	9□ Unknown										
	S, F	res tha igned l be det	b	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	derlying ca	ause give	n in Part I.			2 ⊒•No		e cause of death?	
	Vital Records,	w require been sig	Completed								,	out plan			
	Rec	ne law has l	Idm								Mas an autopsy performe		prior to com death?	sy findings available pletion of cause of	
	tal	ysician: The Is certificate hi director, page	e Co	25. Was case referred to medical					26. Place of D	1 Y		No	1 ☐ Yes 2	2 No	
	5	/sicia s cart direct	O B	ayaminer?	lospital: 1 Inpatient 2 @	ER/Outpatien	t 3 DO	A Othe		Home 5		e 6 🗆 O	ther (Specify)		
	Jor a	ding Phy	n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury Work	at	28d. Descr					
	Sior	tendin leath. tor: Af the fur	catic	2 ☐ Accident investigation			М		′es 2 □ No						
	Division of	l or Att after de Direct J in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	et, factory	, office			on (Stree Town, S		nber or Rural	Route Number,	
		To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours after death. within 24 hours after death. completely filled bliector: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	dical	29a. Certifier 1 Certifying Physical Control one) 2 Medical Examination	sician: To the best of my knoner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date and pla inion, death oc	ce, and due to curred at the ti	the caus	se(s) and n	nanner as sta , and due to	ited. the cause(s)	
	, F	To th withir To th comp	Me	29b. Signature and title of certifier	7		290	License	number				ed (Month, D		
		N		222			į	000	5088	2		01/20	0/2000	į.	
	1	1	18	30. Name and address of person who co	empleted cause of death (Item	1 23a) (Type,	Print)	WITE	1671+46	ension	م المعارد	0/) 2/	742		
	4			31 Date filed (Month Day Year)	32. Registrar's Signa		4					- '			
		Sta		IAN 2.7 2	10/	14 1	- N	,							

			1 - For State Registrar	State of Maryla		artment of rtificate o				111	06	03465
			Registrar  1. Decedent's Name (First, Middle, L.	anti	06	Tillicale U	Dealii		2. Date of Deat	eg. No.	6	3. Time of Death
F	Physici	an							Month	Day	Year	4.30 P M
	/Medic		Raymond William						January	T	004	
r I	Examin	er	4a. Facility Name (If not institution, g			4b. City, Town	n, or Location of	of Death			y of Death	
			1035 Mt. Aetna l				rstown ar IfUnder:	OA Hre	0.00-1		hingt	
	uneral			Sex 7. Age (In yrs	s. last birthday) Yrs.	Months Day		Min.	<ol> <li>Date of Birth (Month, Day,</li> </ol>	Year)	Coul	
Di	rector		219-20-3818	74	115.				Oct. 7	1929	Penn	sylvania
pur	<b>&gt;</b>		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation					1.	10d. Inside City Limits
laryl	유를	ក										1 ☐ Yes 2 ☑ No
94	- 8	ect	Maryland Washi	ngton	наде	rstown 10f. Zip Code				0g. Citizen of	M/hat Cou	
vith t	Den	by Funeral Director	10e. Street and Number						'	-		ind y r
Ę.	123	E	1035 Mt. Aetna 1	· -			1740				S.A.	1- 8
eb :	met a	n ne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify Co	if Hispanic Ori uban, <b>M</b> exican	gin? (Spe 1, Puerto f	city Yes or No- Rican, etc.)		ce - Ameni ack, White,	can Indian, etc.
်န္နီ ခြ	5	Y.	1 Never Married 2 Married	1 □ Yes 2 1 No If Yes, Give		1 ☐ Yes 2 <b>X</b> N	lo Specify:			Speci	fy: T.T.	. <del></del> .
<b>21215-0036</b> of within 72 hours after deeth with the Maryland glene.	ura E X	D D	3 X Widowed 4 ☐ Divorced	Year or Dates:	1 40. 0					10) 10: 1 -( 1		nite
2 2		Completed	15. Decedent's (Specify only highest of	Education rade completed)	16a. Dece	dent's Usual Occ kind of work dor DO NOT use reti	cupation ne during mosi ired)	t of workir	ng	16b. Kind of E	susiness/in	dustry
و غِيَّا الْحَادِ 19 غِيَّا الْحَادِ	han a	ם	Elementary/Secondary (0-12)	College (1-4or 5+)						D 1	0	
0 pg	2		Unknown  17. Father's Name (First, Middle, Lat	0	Drive	r/Sales		rde Namo	(First, Middle, M	Bread		any
D et la f	p of	Be								naiden Sunna	,,,,	
Mer Series	nark natic	P P	Howard W. Stodd		401.44.00	411 (0)	Iola			0) T	O T	0.41
Maryland  of 2 should be file th and Mental Hy	importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship			ng Address (Stre				Ť		
and and teeltheelth	m 27 her t		Patti L. Butler	- Daughter		7 Manor of Strike of				sboro. 20c. Location		land 21713
O S	if ite		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3	1	cemetery, cre	matory or other p	olace)		4.1	zoc. Location	- City or 10	own, State
Fag ment	ent:		' 4 ☐ Donation 5 ☐ Other (Spec			Cemete		1/26/				Maryland
Baltimore, permit. Pages 1 a	y inj		21. Signature of Funeral Service Lig	ensee '	400	2. Name and Add						
<b>0</b> 83	F 29		coul!	////anacco	4	15 E. W	ilson E	31vd.	Hager	stown,	Mary	land 21740
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the de- ty one cause on each line.	ath. Do not en	ter the mode of d	tying, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition	A	We se	lan	10001	·Non	. 1 -			Onset and Death
1	edical		resulting in death)	Due to (or as a conse			aver	usn				7
Exa	miner			b								
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying	Due to (or as a conse	quence of):							
pe m	ansi	Examiner	Cause (Disease or injury that initiated events	c							1	
o, š	an ar rial-tı		resulting in death) Last	Due to (or as a conse	quence of):				-			
3760, ate be executed	hysicien and the burial-transit	cal		d								
<b>68</b>	as th	led								-		
. Box 68 deeth certifica	use	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		⊒Ectopic pregnar	nov				ate of delive	
<b>©</b> ∰	e att	icla	in the past 12 months?	4☐Pregnant at time of		Other (specify)				М	onth	Day Year
Records, P.O.	ed by the attending p deteched for use as	Physician/Med	9 Unknown	9∐ Unknown								
s the	pe del	by P	Part II. Other significent conditions	contributing to death but not re	sulting in the u	nderlying cause	given in Part I.		23e. Did tob	acco use con	tribute to the	he cause of death?
Records,	n sig	P P							1 ☐ Ye	s 2□No	3 Prot	pably 4 □Unknown
လ န	s been si	Completed							24a. Was ar		Were auto	ppsy findings available
<b>2 3 3 3</b>	e he	E							autops	ned?	death?	mpletion of cause of 2□ No
<u>a</u> <u>a</u>	ificet or. pi	Ö	25. Was case referred to medical				26 Place	of Death	1 Yes 2		1 ☐ Yes	20 100
of Vital Physician:	this certificete hes al director, page 2	00	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA	Ther.		ne 50 Reside	•	hor /Specif	541
₽ ₹	r this aral d	); To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				8d. Describe ho			9/
<b>9 a a</b>	Afte	to	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		Injury		Vork? □Yes 2□1	No				
Vislon Attending or death.	ctor y the	fica	3 ☐ Suicide 6 ☐ Could not	289. Place of Injury - At	home, farm, sti	reet, factory, offic	e e	2			ber or Rura	al Route Number,
Division of Vital of or Attending Physician: Taffer death.	Director: d in by the f	Certification;	4  Homicide	building, etc. (Spec	city)				City or Town	, State)		
spite	nara / fille		29a. Certifier 1 Certifying	Physician: To the best of my kr	nowledge, deat	h occurred at the	time, date and	d place, a	nd due to the ca	iuse(s) and m	anner as s	tated.
Div To the Hospitel or within 24 hours afte	To the Funaral Director: After completely filled in by the funer	Medical	(Check only 2 Medicel Ex	aminer: On the basis of examir and manner stated.	nation and/or in	vestigation, in my	y opinion, deat	th occurre	d at the time, da	ite and place,	and due to	o the cause(s)
ro th vithin	ro th	M	29b. Signature and title of certifier				ense number			9d. Date signe	ed (Month,	Day, Year)
	. •		I May ja.	19 Jual		D	2836	5		1-2	3-04	4
			30. Name and address of person wh	o completed cause of death (ite	em 23a) (Type.	Print)				- ,		
			MANZAR.	J.SHAM.	368 n	ull SI	recl-	- Ne	agriotor	un e	2170	10
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature /	ede						
196	Registr	ar	JAN 232	004 threen	0. 100	CAGE & P						

			1 - For State Registrar		aryland /		artment of F			, ,	iene eg. No.	2004	1. 17	
>	Physici /Medic	cal	Decedent's Name (First, Middle Deanna Lynn S†  4a. Facility Name (If not institution,	ottlemyer	1		4h Ch. Taur	-1	-( Death	2. Date of Dea Month	Day 7 21.	Year 2004	3. Time of Death 12:44 P	
	Examir Funeral Director	ier	15717 Clear Spr	ing Road	ge (In yrs. last)	<i>birthday)</i> Yrs.	4b. City, Town, c  Willi  If Under 1 Year  Months Days	amsipo:	rt 24 Hrs.	8. Date of Birth (Month, Dey, 0ct.8,1	Year)	Washing 9. Births Cour	gton place (State or Foreign phry) sylvania	
Maryland 21215-0036	and ZIZIS-UU36  be filed within 72 hours after death with the Maryland that Hyglene. ad other than "natural", or items 23a or 28a-f ahow avent, I'm Madical Examirant minite notified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  West Virginia  Berkeley  Martinsburg  10e. Street and Number  51 Labonte Drive  11. Marital Status  11 Never Married  12. Was Decedent Ever in U.S. Amed Forces? 1   Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes   2   No Specify:  15. Decedent's Education  (Specify only highest grade completed)  Elementary/Secondary (0-12)  12. Was Decedent Ever in U.S. Amed Forces? 1   Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1   Yes   2   No Specify:  Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of working (Give kind of work done during mo								Race - Americ Black, White, recity: Whi	0d. Inside City Limits  1 □ Yes 2 No  htty?  can Indian, etc.  †e  dustry		
	is 1 and 2 should be of Health and Mental item 27 is marked of other traumatic averages.		19a. Informant's Name/Relationsh  Mervin R. Stott  20a. Method of Disposition		and 5	1 La	g Address (Street bonte Dr	and Numbe	or or Rural Ma <b>r</b> †i	nsburg,	City or To	5401		
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service)	ecify)		Spr	ing Ceme  Name and Addre	tery .	Jan.2	6,2004	Jones			
68/60,	Physician /Medical Examiner		23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. OMPRES  Due to (or as  b. Due to (or as	d the death. Done.  5100 a consequence a consequence a consequence	e of):				respiratory arre			Approximate Interval Between Onset and Death	
O. BOX	that the death certificate ed by the attending phys detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of deli Month			
ecords, P.	w requires that the been signed by should be detact	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.										e cause of death?	
каі нес	The law ate has b page 2 st	e Completed	25. Was case referred to medical								ed?	prior to con death?	nsy findings available apletion of cause of	
Jing Phy Jing Phy After this funeral d		Certification; To B	examiner?    National   Suicide   Could not be determined   Seminary									anglad	inachinery	
	To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the 1	edical	29a. Certifier  (Check only one)  1 Certifying 2 Medicel E	Physician: To the best caminer: On the basis of and manner sta	f examination a	ne death	occurre at le tim estigation, my or	ne, date and pinion, death	place, an	d due to the car	use(s) and te and plac	manner as sta	ated. the cause(s)	
10	To II Ville	Ž	29b. Signature and title of certifier 30. Name and address of person w	no completed cause of d	11		rint)	.C.M.1			Janua	ary 22,	2004	
	Sta Registr		31. Date filed (Month) Pay, Year)	2004 32 Registr	ar's Signature	111 p	Penn Stre	et, B	altin	nore, Ma	ryla	nd 2120	1	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10 **Physician** 19 Daniel Thomas Stover III 2004 January /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County 3618 Harpers Ferry Road Sharpsburg Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1∰ M 2□ F July 5 2003 Maryland Director 215-67-5448 6 14 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location tems 23a or 28a-f ehow the Medical Exacilmentment be notified at 1 ☐ Yes Ž☐ No Maryland Sharpsburg Washington Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Žip Code 21782 U.S.A. 3618 Harpers Ferry Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 BNo If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel, or Item any injury or other traumatic event, the Mental and page. Black, White, etc 1 X Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Daniel Thomas Stover Jr. Rhonda Suzanne Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3618 Harpers Ferry Foad Sharpsburg, Maryland 21782 Daniel Thomas Stover, Jr. Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Samples Manor Cemetery Jan. 22,2004 Sharpsburg, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21. Signature of Funeral Service Licensee rough 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final tochonce Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy Year in the past 12 months? Month Dav 4☐ Pregnant at time of death 5 Other (specify) 1 TYPS 2 NO 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? s after dea. of Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel o within 24 hours aff To the Funerel Di tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1198 KENIY 31. Date filed (Month) 32. Régistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Amend Item #23a,27,28a-f per me G834 8/3/04 tas

State of Maryland / Department of Health and Mental Hygiene

1- For Unpend Item #1,23a,27 per me G828 2/24/04 tas

Certificate of Death

Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 0701 Ам SHAWN DEAN SUTTON 23, 2004 JAN. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Min. Min. March 13,1962 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 216 64 3970 41 Yrs. Georgia Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Md . Montgomery Ashton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 18801 Mink Hollow Road 20861 or items 23a United States Funerai death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Contractor Home Improvement permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event one: 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elvin Dean Sutton Lavada Lois Groskurd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18801 Mink Hollow Road, Ashton, Maryland 20861 Angalene P. Sutton / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1/24/04 Metropolitan Crem. Alexandria, Virginia \*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Muriel H. Barber Funeral Home Burei P. O. Box 5038, Laytonsville, 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one ach line.

Venlafaxine And Methadone Intoxication Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Cardiac Arrythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the burial-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury Fourth, Day Year) 28b. Time 28d. Describe how injury occurred After To the Hospitel or Attending Natural 5 🗌 Pending 1/23/2004 investigation 6:00 1 ☐ Yes 2 😾 No M within 24 hours after death. To the Funerel Diractor: / 2 Accident Unknown the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

Residence 28f. Location (Street and 8801) Mink HOTTOW RIL filled in by 4 - Homicide Ashton, Md 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai completely (Check only one) and manner stated. 29b. Sign fure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24, 2004 O.C.M.E JAN. Me 30. Name and address f person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 KORELL MARCAGIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Special Di

Registrar DHMH 17 Rev 1/2001 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sirbaugh Year **Physician** atricia 8.20. AM ouise February 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland 229 Oak Street If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Jul 26, 1942 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign County) **Funeral** 1 ☐ M 2 □XF 218-38-2445 61 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hyglene. Important: If Item 27 is marked other then "natural", or Itama 23a or 28a-f show any injury or other traumatic event, The Medical Examiner must be notified at once. MD Allegany Cumberland Director 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21502 USA 229 Oak Street Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: white 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Lindy's Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Virginia Geatz Walter Andrew Poling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
229 Oak Street Cumberland MD 21502 husband Harold Sirbaugh 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Aurial 2 Cremation 3 Removal from State Restlawn Memorial Gardens 2/5/2004 MD LaVale \*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nam Scarpelli Funeral Home, PA ▶ 108 Virginia Avenue: Cumberland, MD 21502 amus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ćause (Final Cancer Physician luna months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immissirate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use es the burial-transit and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ģ Month Day Year 5 Other (specify) ed by the a 1 ☐ Yes 2 ☑ No 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Nos 2 No 3 Probably 4 Unknown been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1∐ Yes 2 4NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 ZNatural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number lemaan. 0056207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Rd Cumberland MO 21502 HUSAM SEMAAN, M.O Bishop 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 200N FEB 6 Registrar

		- For Unpend Item #2	23a,27,28a-1 pe	r me (	rtment of H	ealth and M 1/04, tas 1 <i>eath</i>	ental Hygi	ene	034/4
		Hegistrar     Decedent's Name (First, Middle, Las			inoato or i	Joann	2. Date of Deatl		3. Time of Death
Physicia	an	Shirley G. Steel	•				Month	Day Yeer	
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uneral		5. Social Security Number 6. Se	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Forei
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f show	5	MD Cecil	D;	sing Si	1.10				1 ☐ Yes 2 ☐ N
28a-f	Director	10e. Street and Number	, Ku	sing si	10f. Zip Code		10	g. Citizen of What C	ountry?
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Items 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Anned Forces?	. 13. W	as Decedent of H	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No-	14. Race - Am Black, Whi	
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other ant, I		17. Father's Name (First, Middle, Last)		- 110111	emaket	18. Mother's Neme	(First, Middle, N		
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27 is		Marsha Steele/da	ughter	P.0	. Box 108	34, Rising	Sun. M	D 21911	
Itam		20a. Method of Disposition	20b. Pla		ition (Name of atory or other plac		ate 2	Oc. Location - City or	Town, State
iry or		1 ☐ Burial 2 🛣 Cremation 3 ☐ 3 ☐ Onation 5 ☐ Other (Specify					.A.	Rising Sur	ı, MD
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page 2	E C						autopsy	ed? prior to death?	completion of cause of
certificate rector, pag	0	25. Was case referred to medical				26. Place of Death	(Check any and		2□ No
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₽ Fe		27. Manner of Death	28a. Date of Injury 2 FOUND Day Year) F	28b. Time of	28c. Injury Work	at 2	8d. Describe how		,, 112 50017
r: After	Certification;	1 □Natural 5 □ Pending 2 □ Accident investigation	2/2/04 1	Out 1:45 A			Unknown		
racto by th	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office	2	8f. Location (Stre City or Town,	et and Number of Ri State) 292 Ho	ral Route Number Rd
within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral transfer.			Residence				Rising S	Sun, Md	
Fune ely fil	edical	(Check only 2 Medicel Exem	vsician: To the best of my knowl iner: On the basis of examination	ledge, death on and/or inve	occurred at the timestigation, in my op	e, date and place, a sinion, death occurre	nd due to the car	use(s) and manner as te and place, and due	stated. to the cause(s)
To the Fur completely	Med	one)	and manner stated.						
<b>5</b> 8		29b. Signature and title of certifier	•		29c. License			d. Date signed (Mont	
		- will			O.C.M	. E.	ŀ	'ebruary 3	, 2004
		30. Name and address of person who o		23a) (Type, P	rint)				
		ANA RU	B10, MD			- 01	D 3 . 1	re, Maryla	. 7. 04004

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Mary	ylanu /	Certificate of		,	giene Reg. No. 🧻 🖟	11.	021.71
	Physici		Decedant's Nama (First, Middle, Last)     Betty	N.	Stauffer		2. Data of Dea Month January	Day	Yaar 004	3. Tima of Death
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			College View Nursing Center  5. Social Sacurity Number 6. Sex 7. Aga (//			Frederick If Undar 24 Hrs.	0.00			County
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9036	filed within 72 hours effer death with the Maryland Hyglene. The than "natural", or items 23a or 28a-f show mt, the Madical Examiner must be notified at	<u>a</u>	11. Marital Status  1 □ Nevar Marriad 2 □ Married  3 ☒ Widowad 4 □ Divorced  12. Was Dacedant Eva Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Yaar or Datas:	r in U,S.	13. Was Decedant of H If Yas, specify Cub 1 ☐ Yes 2 ☒ No		acify Yas or No- Rican, atc.)		ce - Amaric ck, White, V:Whit	
Maryland 21215-0036	within 72 hours lene. than "natural", the Wedical Exe	To Be Completed	15. Decedent's Education (Specify only highast grede completed)  Elemantary/Secondary (0-12)  Collega (1-4or 5+)	16	Sa. Decedent's Usual Occup (Give kind of work dona life. DO NOT use retire Sewing machin	pation during most of working d) ne operato	or	16b. Kind of B		ufacture
/land 2	12 should be filed within and Mentel Hygiene.	To Be Co	17. Father's Neme (First, Middla, Last) David T. Forney			18. Mothar's Nama	(First, Middle, omi Hahr	Maiden Suman		
			19a. Informant's Name/Ralationship (Type, Print)  Carroll D. Stauffer / son		9b. Mailing Addrass (Straat 7965 Woodland	d Drive	Hanover	, Penns	sylva	nia 17331
Baltimore,	9 0 1				of Disposition (Name of tery, crematory or other plac green Memoria		Feb 2	<sup>20c.</sup> Location - Finksbu	,	<sub>wn, Stata</sub> Iaryland
Ball	permit. Pag Depertment important: I any injury o		21. Signatura of Funeral Service Licensaa  Hunn  Lunn		22. Nama and Addra		iles Fu	neral H Taneyt	ome own,	MD 21787
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-	death he atte	sicia	Part II. Othar aignificant conditions contributing to death but no	ot rasulting	in tha underlying causa giv	an in Part I.	23b. Did to	bacco usa cor	ntribute to	tha causa of death?
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	nysician: The law i iis certificete hes b I director, page 2 sl						1 □ Ye	s 200No	1 🗆	]Yas 2□ No
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Divis	al or Atte s efter de il Directo ed in by th	Certification:	3 ☐ Suicida 6 ☐ Could not be determined 28e. Place of Injury-building, atc. (S	At homa, f	farm, straat, factory, offica	2	8f. Location (St. City or Town	reet a <i>nd N</i> umb n, Stata)	er or Rura	Route Number,
	To the Hospital or Attending Physwithin 24 hours efter deeth.  To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Cartifier (Check only one)  1 CertifyIng Physician: To the best of my one)  1 Medical Examinar: On the basis of axa and manner statad.	ımınation ei	ga, deeth occurred at tha tim nd/or investigation, in my op	ne, data end place, a pinion, death occurre	nd due to the ca	use(s) and ma ate and place, a	nner as stand due to	ated. the cause(s)
)	With Total		29b. Signatura and titla of continar		29c. Licansi D 43	091		9d. Data signad	04	,
	5		30. Nama and addrass of person who completed cause of death	(Item 23a)	(Typa, Print) 801 TOLL	11	1.77	/ 1	14	A 2124
	Stat	e	31. Dete filed (Month, Day, Yaar) 32. Ragistrar's S	Signatura	801 10TT	HOUSE	IVE, The	cherick	-, M.	5 21101
	Registra	_	FEB - 6 2004	1	Sperker .					
DH	MH 16 Rev 6/95				ORIGINAL					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4:15 AM **Physician** Sidney Ethel Sindy 2 40 /Medical 4c. County ol Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner mberland Allegan acred Heart Hospital If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day May 19, May 19, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** 1 ☐ M 2 🖫 F 213-22-3934 93 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar nent of Health and Mantal Hygiene.
and of Health and Mantal Hygiene.
and It if learn 27 is marked other than 'naturs', or Itama 23a or 28a-1 show ury or other traumatic event, its Madical Examinationals be notified at Allegany Cresaptown MD 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14817 Winchester Road, SW 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assistant Supervisor Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Dora Sindy Hose unkown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 52 Parkside Blvd. **Benay Wharton** LaVale MD 21502 cousin 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State Hillcrest Memorial Park 1/29/2004 permit. Page Department of Importent: If any injury or once. Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Address of Pa 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death ō Month Day 5 Other (specify) ☐ Yes 2 ☐ No P.O. detached the th 9 Unknown Part II. Other significant conditions contribering to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, should be 21010 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 21 No 1 Yes certificate 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 29 No 1 Inpatient 2 ER/Outpatient 3□ DOA in by the funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deal To the Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 161 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

Amended Item#6

	2004	State of Ma			Health and M	Mental Hy	giene	
1 - State Regist			C	ertificate of	Death		Reg. No.	
DI CONTRACTOR OF THE CONTRACTO	s Name <i>(First, Middl</i> e, La ond Richard	•				2. Date of De Month JANUAR	Day Yea	1.4
	ame (If not institution, giv	e street and number)		4b. City, Town,	or Location of Death		4c. County of D	
Funeral Director 5. Social Security 220-1	0 3330		E e (In yrs. last birthd 86 Yrs	Months Davs	r If Under 24 Hrs.	8. Date of Bir (Month, Da Sept. 1	WASHING 9. th 19. Year) 3,1917 Ma	GTON Birthplace (State or Foreign Country) aryland
0	10b. County		10c. City, Town or	Location				10d. Inside City Limits
Mary1	<b>`</b>	gton	На	gerstown				1 □Yes 2 No
10e. Street	<sub>nd Number</sub> Daycotah Ave	22110		10f. Zip Code	1740		10g. Citizen of What	•
11. Marital S		12. Was Decedent	Everin U.S. 1		_, ,_	pacify Yas or No	US.	merican Indian,
	or Married 2 Married	Armed Forces?  1 X Yes 2 1  If Yes, Give Year or Dates:		If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp ban, Mexican, Puerto o Specify:	Rican, etc.)	Black, W	
21215-0 ed within 72 ho ed within 72 ho gliene. It is the Medical is Completed 6	15. Decedent's E (Specify only highest gra	ade completed)	(G	cedent's Usual Occuive kind of work done  DO NOT use retin	ipation a during most of work ad)	king	16b. Kind of Busine	ss/Industry
Somple Elements  Comple Elements	y/Secondary (0-12)	College (1-4or 5	*	tool and	dye maker		aircraft	
De fill and the fi	Name (First, Middle, Last,	)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
Deasa 19a. Inform	more Oliver	Toms				Ray Bar		
Barba	nt's Name/Relationship ( ra Iseminger						er, City or Town, State COWn, Md.	
<b>型</b> - 当	of Disposition al 2 □ Cremation 3 □	Removal from State	20b. Place of Dis	sposition (Name of rematory or other pla	3 <i>C</i> <b>0</b> )	Date	20c. Location - City	or Town, State
Timent thent:	ation 5 ☐ Other (Specif	<u>'</u> ሃ)	Rose H	ill Cemet		23/04		own, Maryland
Baltimore, permit Pages 1 and p	e of Funeral Service Licer	Me	mni S				NERAL HOMI stown, Man	E cyland 21740
	Enter the disease, or com or heart failure. List only Cause (Final ondition Jeath)	а. Д	the death. Do not the.  Much described a consequence of:	enter the mode of dy	en A		rest,	Approximate Interval Between Onset and Death
Examiner	list conditions,	b	ongest	ive H	eout 7	aileu	e	2 Montes
Lesulting in		c	a consequence of): a consequence of):	1 denn	paurs			4 Mondis
68760, tificate be extiricate be extiricate be extire physician as the buria	(	d						
BOX Clan/N Clan/	cedent pregnant ast 12 months? s 2 \sumbox{No} known	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	у		23d. Date of d Month	lelivery Day Year
COrds, P  W requires that been signed t  should be deticated by PI  leted by PI	significant conditions o	contributing to death bi	ut not resulting in the	underlying cause gr	ven in Part I.			to the cause of death?  Probably 4 Unknown
The law requir					<del></del>	24a. Was: autop perfor	sy prior to	
25. Was cas	referred to medical	I In-mittal		1.	26. Place of Deat			
Division of Vital Records, P.O.  To the Hospitel or Attending Physician: The law requires that the d within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the completely filled in by the tuneral director, page 2 should be detached completely filled in by the tuneral director, page 2 should be detached.  Medical Certification: To Be Completed by Physic Seed.  Seed.  And The Complete of the complete of	f Death	Hospital: 1 ☐ Inpatie  28a. Date of Injui (Month, Day	v 28b. Time	of 28c. Inju			ence 6 Other (Sp low injury occurred	pecify)
Division C Division C	de 6 Could not b	e 28e. Place of Injubulding, etc	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S City or Tow	Street and Number or I n, State)	Rural Route Number,
DIVI  To the Hospitel or At within 24 hours after 6 to the Funeral Direct completely filled in by 36 council (Check one)  Medical Certifit (Check one)  79	1X Certifying Ph	nysician: To the best on niner: On the basis of and manner sta	examination and/or ited.	investigation, in my	opinion, death occuri	ed at the time, o	date and place, and di	as stated. ue to the cause(s)
THE STATE OF SIGNATURE	e and title of certifier	h. / .		29c. Licen	se number	2	29d. Date signed (Moi	nth, Day, Year)
1	Manger !	1 Leef	ί.	E	28365		1-20	Cq
30. Name ar	address of person who	completed cause of de	eath (Item 23a) (Typ	e, Print)	se number ) 28365 Street	Hage	House	MO 20740
State 31. Date file	(Month, Day, Year) JAN 2 2 21	32. Registra	ar's Signature	and the		0		

_		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	cal -	Thomas Thompson	City, Town, or Location of Death		0, 2004 4c. County of Death	0750 A <sup>M</sup>
In Physician: The law requires that the death certificate be executed that the death certificate be executed the record of the state of	The state of the s	BALTIMORE CITY		40. 0001119 01 200111		
		334-74-7132 13⊠ M 2□ F 29 Yrs. Mor	Under 1 Year If Under 24 Hrs.  Inthis Days Hours Min.	8. Dete of Birth (Month, Day, Aug. 6,	Year) Coul	olece (State or Foreign ntry) yland
ahow ed at	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Baltimore Townson	n		1	10d. Inside City Limits 1 ☐ Yes 2 ▼No
288-i	rect	10e. Street and Number 10	Of. Zip Code	10	g. Citizen of What Cour	ntry?
23a o	a D	205 Fast Joppa Road Unit 304	21286		USA	
al', or Iteme Examinar na	þ	1 127 Never Married 2 □ Married 1 □ Yes 2 127 No	Decedent of Hispanic Origin? (S <sub>I</sub> , specify Cuban, Mexican, Puerk es 2 X No Specify:	pecify Yes or No- Rican, etc.)	14. Rece - Americ Black, White, Specify: Whi	etc.
"natur	leted	(Specify only highest grade completed) (Give kind life. DO N	S Usual Occupation of work done during most of work IOT use retired)	king 1	6b. Kind of Business/In	dustry
r than	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Cons	struction		Resident	ial
lental Hyg ked othe ilc event,	o Be C	17. Father's Name (First, Middle, Last) Harry L. Thompson, III		ne (First, Middle, M ry Hartze		
ls mar	-		Idress (Street and Number or Ru .W. 10th Court			
Heaith em 27 ither tu		20b. Place of Disposition	(Name of		n Beach, FL	
ent of ht: If it ry or o		1 Burial 2 IXCremation 3 Removal from State 1 Donation 5 Other (Specify)	tory 20		Baltimore,	MD
Departm Importer any injur		21. Signature on Funeral Service Licens 22. Nar Barri	me and Address of Facility ranco & Sons, P Gov. Ritchie H	.A. Seve	erna Park F	
		Part . Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.				Approximate Interval Between
nysician		Immediate Cause (Final disease or condition resulting in death)  NARCOTIC INTOXICAT	LION			Onset and Death
		Due to (or as a consequence of):				
===	e l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
ysician and ne burial-transit	Ical Examir	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  d.				
ing ph e as th	ysiclan/Med		opic pregnancy er (specify)		23d. Date of deliv Month	ery Day Year
the attend			lying cause given in Part I.		acco use contribute to t	
n signed by the attenduld be detached for us	by	Part II. Other significant conditions contributing to death but not resulting in the under		1 □ Ye		bably 4 Hunknown
ate has been signed by the attend page 2 should be detached for us	leted by	Part II. Other significant conditions contributing to death but not resulting in the undert		24a. Was ar autopsy perform	prior to co death?	
sertificate has been signed by the attendector, page 2 should be detached for us	leted by	25. Was case referred to medical examiner?	0.5	24a. Was ar autops) perform 1 Yes 2	prior to co death? No 1A Yes	opsy findings available ompletion of cause of
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			1 - For State Registrar	State of	Maryland .	_	artment of H			, ,	iene	104	() i	15
	Physici	an	1. Decedent's Name (First, Middle,							2. Date of Deat Month		Year,	3. Time of D	eath
<b>.</b>	/Medic	al	BARBARA ANN VA		agr)	-	4b. City, Town, or	l continu	of Dooth	JANUAR		2004	0430	М
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	Funeral			Sex 7.	Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under		8. Date of Birth	Year	0.014		-oreign
Н	Director		290-54-4389	1 ☐ M 2 🖾 F	47	Yrs.	Months Days	nouis	191411.	JAN. 16,	1957	Cour	OHIO	
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation			· »		1	0d. Inside City	Limits
	Mary	to	MARYLAND WAS	HINGTON			I	BOONS	BORO				1 □Yes 🥻	<b>∏</b> No
	ath with the Marylan 23e or 28a-f show ust be notified at	Directo	10e. Street and Number				10f. Zip Code			10	0g. Citizen of	What Cour	itry?	
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	after des or Items	Funeral	11. Marital Status 1 ☐ Never Married 2☑ Married	12. Was Deceded Armed Force 1 Tyes 2	es?	13.	Was Decedent of Hi If Yes, specify Cubar	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ack, White,		
9-003p	72 hours after death with the Maryland neturel; or Items 23e or 28e-f show alsal Examiner oust be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		1 ☐ Yes 2 🎇 No	Specify:			Speci	ity.	HITE	
<u>ب</u>	72 ho	Completed	15. Decedent's (Specify only highest of	Education grade completed)	1	(Give	dent's Usual Occupa kind of work done d	lurina mosi	t of work	ina	16b. Kind of I			
Z	within then then	mpl	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use retired, DEMO COORI	)			MARE	EHOUSE	CLUB	
N D	be filed value of the things of the the the the the the the the the the		17. Father's Name (First, Middle, La	st)		L	MINO COOK			(First, Middle, M			מסחס	
au	lid be lental ked c ic eve	To Be	LELAND EDSEL VAN	CAMP						ANN OTT		,		
a Z	s 1 and 2 should f Health and Men item 27 is marke other treumatic	-	19a. Informant's Name/Relationship		1		ng Address (Street a						Code)	7.
Σ.	and and a ealth m 27 in		BARRY O. BOYLE,	HUSBAND	100		16 NETZ I	ROAD,	-				1713	
<u> </u>	m O		20a. Method of Disposition 1 □ Burial 2 X Cremation 3		ate ceme	etery, cren	sition (Name of matory or other place	1			0c. Location			
	permit. Page Department of Importent: If any injury or once.		'4 □ Denation 5 □ Other (Special Signature of Tuneral Service □ o		SMI	-	JRG CREMAT			2004 7606 OL			MARYLA	AND
g	Department of the control of the con		1011 M. [/]	_	M. Dear		BAST FUNE		•	BOONSBO				L3
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	nysician		Immediate Cause (Final disease or condition	,	1,110	2	m.	+0	10-	to n	r Come		Onset and Dea	
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ğ	leath atten	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birtl	h 2 Fetal death	ath 3□	Ectopic pregnancy Other (specify)				1	ate of deliver onth	ry Day Yea	ir
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	requir	sted	_ Bone_	mete	<u> </u>	4 > 1				1 ☐ Yes	s 2 No	3 ☐ Proba	ably 4 Unk	nown
d)	4 5 6	Completed								24a. Was an autopsy perform		Were autop prior to con death?	sy findings ava	ulable se of
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5	ysicie s certi directo	ToBe	examiner?	Hospital: 1 ☐ Inp	atient 2 ER/	Outpatien	t 3 DOA Othe		of Death	ne Resider	nce 6 🗆 Ott	ner (Specify	}	300
5	ng Phy ter thi neral		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of (Month,		b. Time of Injury			-	28d. Describe hov				
<u>S</u>	tendir eath. for: Ai the fu	catle	2 Accident investigat	on he			M 1□Y	'es 2 □ N	-					
DIVISION	or At after d Direct in by	ertification;	4 Homicide determine	ZSO. Place of	Injury - At home, , etc. (Specify)	, farm, stre	eet, factory, office		2	28f. Location (Stre City or Town,		ber or Rural	Route Number	;
	To the Hospitel or Attending Physicien: The i within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	O	29a. Certifier 1 Certifying	Physician: To the be	est of my knowled	dge, death	occurred at the time	e, date and	d place. a	and due to the car	use(s) and m	anner as sta	ated.	
	he Hc in 24 ł he Fu pletely	edical	(Check only 2 Medical Ex	aminer: On the basi and manner	s of examination	and/or inv	estigation, in my op	inion, deat	th occurre	ed at the time, dat	te and place,	and due to	the cause(s)	
	Withi To t	Σ	29b. Signature and title of certifier.	1	1	Mi	29c. License	number	, M	29	d. Date signe	od (Month, D	Day, Year)	
	0,		Thud f	1an	nde	un	al D	46	41	5	01/	d3/C	)4	
كأرفي	×		30. Name and address of person wh	completed cause	of death (Item 23)	a) (Type, I	Print)	C	T .	Hade	n ston	11/10	Mr 11	MI.M
9	Sta	te	31. Date filed (Month, Day, Year)	4 -	istrar's Signature		UIAL		` '	, 11490	010	WII	IL AL	140
	Registr		JAN 23	2004	sem G.	de	Marie J							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** Feb 4, 2004 Wood 6:45am Wilhelmina Н. /Medical 4b. City. Town, or Locetion of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Cumberland Allegany Devlin Manor Nursing Home If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Yeer) 9. Birthplace (Stete or Foreign 7. Age (In yrs. lest birthday) **Funeral** Days 1□ M 2□ F Yrs. MD Director Aug 24, 1911 217-14-4582 92 filed within 72 hours efter deeth with the Marylend 10a. Stete 10c. City, Town or Locetion 10d. Inside City Limits 10b. County r then "neturel", or items 23s or 28e-f show the Medical Examiner must be notified at 1 Ves 2 □ No Cumberland MD Allegany Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1420 Maple Leaf Drive SE 21502 USA Funerai Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give X Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Be Completed by 3√2 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry nd Mentel Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) **Balistics Laboratory** Registrered Nurse 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) h end Mentel F Pages 1 and 2 should be Anna Klavuhn Harrigan Lawrence J. Harrigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 1420 Maple Leaf Drive Cumberland MD 21502 Depertment of Health Important: if item 27 i foster son John Martin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 5 1 → Burial 2 □ Cremation 3 □ Removal from State 2/7/2004 MD 4 Donation 5 Dother (Specify) SS Peter Paul Cemetery Cumberland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 ramis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or idear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Myocarlix Examiner Physician/Medical Examiner CURUNANY or Attending Physician: The law requires that the death certificate be executed ettending physician end for use es the buriel-trensit Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of): resulting in death) Last Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 Tes 2 No 3 Probably → Unknown ۶ ک 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy hes 1 ☐ Yes 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Rursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation **1** ■ Matural 1 ☐ Yes 2 ☐ No 2 Accident Director; / 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours eft To the Funerel Dil completely filled in Timetrifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2/4/2004 D21244 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) JESUS TAN, FROSTBURG PLAZA, FROSTBURG, MD 21532 M.D.

32. Registrat's Signeture

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day

			1 - State Registrar Amend I tem#24	State of Mary	•				jiene Reg. Ng.	11. 031.77
		J.C.	Decedent's Name (First, Middle, L.		112/04 500	timodic or i	Douin	2. Date of Dea	N/MI	3. Time of Death
	Physici	an	Oval G.	Whetzel				Month 2	_ ′	Year 8:55 PM
	/Medic		4a. Facility Name (If not institution, gi			4b. City, Town, or	r Location of Dea		4c. County o	
	Examin	er			1/771		ER LAN		ALLE	
			SACRED HEA  5. Social Security Number 6.		17AL	If Under 1 Year				9. Birthplace (State or Foreign
	Funeral			1 <b>∑</b> M 2□F	81 Yrs.	Months Days	Hours Min			WV
	Director		Usual Residence of Decedent		01			Sept.9	, 1922	m v
	iand ow		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Many	ō	WV Hamps	hire	Romney					1 □ Yes 2√2No
	the 28a	Directo	10e, Street and Number	TITE .	Ronarcy	10f. Zip Code			10g. Citizen of Wi	hat Country?
	with with		IIC (2 D 2200			267	57		USA	
	eath	Funeral	HC-63 Box 2390  11. Marital Status	12. Was Decedent Ever	in U.S. 13.1			Specify Yes or No-		- American Indian,
	ter d	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		f Yes, specify Cuba	ın, Mexican, Pue	rto Rican, etc.)	Black	, White, etc.
ž	ours after death with the Marylan rel', or flams 23e or 28e-f show Exament mult be multiped at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 43-	-45	1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
5-0036	itled within 72 hours after death with the Maryland Hygiene. ther than "natural", or flams 23a or 28a-f show ont, the Maulical Examere interior incitilists at	Completed	15. Decedent's 6		16a. Dece	dent's Usual Occup	ation		16b. Kind of Bus	iness/Industry
ב	7 uic 7	pie	(Specify only highest gas Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of word)	orking		
	T the	E	12	Conogo (1 401 51)	1	aborer			Coca C	ola Plant
0	be filed within 72 ho ital Hygiene. Id other than "natur event, the Madical	BeC	17. Father's Name (First, Middle, Las	it)			18. Mother's Na	me (First, Middle,	Maiden Sumame	)
Maryland		To B	Parran Whetzel				Rebeco	a Wilkin	S	
>	d 2 should th and Men 7 is marke traumatic	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ig Address (Street	and Number or F	Rural Route Numbe	r, City or Town, S	itate, Zip Code)
Σ	and 2 ealth a n 27 is		M. Pauline Whe	tzel	нс-є	3 Box 23	90 Rom	ney, WV 2	6757	
a O	一工資金		20a, Method of Disposition		Ob. Place of Dispo			Date		ity or Town, State
<u></u>	0°= 5		1 Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec	Removal from State	Fort Ashb		"   2/	6/04	Fort Ash	by UN7
altimore,			21. Signature of Funeral Service Lice			. Name and Addres				me Hamp. LLC
n n	permit. Departr Imports any Inju			0 (10.				Romney		
Mer	_		23a Part1 Finter the disease or con	motications that caused the						Approximate
			23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final	y one cause of each line.		- (	7 ,			Interval Between Onset and Death
	Physician		disease or condition resulting in death)	a. Cardi	ogeni	c Sta	DCK	<u></u>		50875
¢	/Medical Examiner		1	Due to (or as a co	insequence of):	200-L				
		_	Sequentially list conditions, if any, leading to immediate	b. Afrial	YChr	XXXX	On			
	sit s	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	insequence on.		1.	0000	0.0	
	and and -tran	кап	that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of	bug	unive	MX521	am	٠
Š.	cate be executed physicien and the burial-transit			M . ( 0	i C			hessi		
09/8 8	ate t	dical	•	La Pleto	Tasic	Squan	was C	17 Ca	ncer	
9		• t	IF FEMALE:		5040					
X Q	death certifii e attending I ed for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy	,		23d. Date Mont	
	0 0	Sici	1 ☐ Yes 2 ☐ No	4□Pregnant at time 9□Unknown	of death 5	Other (specify)				25,
J O	at the	Physician/M	9 Unknown					40 5111		
	law requires that the de as been signed by the a . 2 should be detached f	by	Part II. Other significant conditions	contributing to death but no	ot resulting in the ui	nderlying cause give	en in Part I.			oute to the cause of death?
Vital Records,	w require been si should t					<del></del>		1 U Y	es 2□No 3	Probably 4 Unknown
ပ္က	law ras be	Completed						24a. Was a autops	n 24b. W	ere autopsy findings available or to completion of cause of
ř	0 5 6	mo						perfor	med? de	ath? ☐ Yes 2 ☐ No
ta	iician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of De	eath (Check only or		
	Physician: rthis certific ral director.	0	examiner? 1 ☐ Yes 2 <b>2</b> No	Hospital:	2 ER/Outpatien	t 3 DOA Othe	er: 4 Nursing	Home 5 Resid	ence 6 Other	(Specify)
ö		r.	27. Manner of Death	28a. Date of Injury (Month, Day Ye.	28b. Time of	28c. Injun Worl	/ at	7	ow injury occurred	
0	nding I th. : After e funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		ar) Injury		Yes 2 □ No			
Division	or Attanding after death. Director: Afte in by the fune	iii Ci	3 Suicide 6 Could not determine	200. Flace of Injury	At home, farm, str	eet, factory, office		28f. Location (S	treet and Number	or Rural Route Number,
S	al or At after of Direct d in by	Certification;	4  Homicide	building, etc. (S	респу			City or Tow	i, State)	
	nours nera		29a. Certifier 1 Certifying P	Physician: To the best of maniner: On the basis of exa	y knowledge, death	occurred at the time	ne, date and place	e, and due to the c	ause(s) and mani	ner as stated.
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Exa	aminer: On the basis of exa and manner stated.	mination and/or in	estigation, in my of	pinion, death occ	surred at the time, of	ate and place, an	d due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	7		29c. License	e number	3	9d. Date signed	(Month, Day, Year)
	- > - 0		1900 Class	CAMP !	4.7	0-1	757	6 6	ebmai	7 3 12004
			30. Name and address of person labor	and lated cause of death	(Item 23a) (Type	Print)				0 1000
			Dr John Mal	name and	35000	TRIVE	Cim	perlan	a. Mr	181203
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrars	Signature	AL VC		X 100 1	1.00	
	Reaistr		FEB =	£ 2004 ▶ Æ	Cise It	Doseles				

			For State Registrar	State of Maryla	nd / Depart	ment of Health	n and M		e2004	03478
	+ 3		Decedent's Name (First, Middle, I	.ast)	^			2. Date of Death		3. Time of Death
and the same	Physici VMedic	al	Munike		fer.		(8.5)	2 4	2004	10:48P.M
	Examin	er	4a. Fecility Name (If not institution, g	1 1 /	21 4	City, Town, or Localid	On of Death	4	c. County of Death	0,
	Funeral Director			OL / C + O W N   7. Age (In yrs		Under 1 Year If Undonths Days Hour	der 24 Hrs.	8. Date of Birth (Month, Day, Yea		hplece (State or Foreign untry)
3			Usual Residence of Decedent							
d 21215-0036	c nous are used with the marylar latural", or Itams 23a or 28s-f show trai Examiner must be notified at	tor	10a. State 10b. County  BALT	IMORE 100. C	city, Town or Locati	EE LANI	7			10d. Inside City Limits 1 ☐ Yes 2 No
£	or 28c	lrec	10e. Street and Number			Of. Zip Code		10g. 0	Citizen of What Cor	untry?
1 4	8 23a	rail		etown Roas	ď.	2105.			TURH	SEY.
13	fram	Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?		Decedent of Hispanic s, specify Cuban, Mexi	Origin? (Spe can, Puerto f	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5-0036	, je	by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	10	Yes 2 No Spec	ity:		Specify:	hite.
20-5	natur	Completed by	15. Decedent's (Specify only highest of	Education grade completed)	16a. Decedent	's Usual Occupation f of work done during m NOT use retired)	nost of workin	16b.	Kind of Business/l	ndustry
2121	than	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)	nonce	4			+ ha	00
D 2	Hygiene.	e Cc	17. Father's Name (First, Middle, La.	st)	TICING		ther's Name	(First, Middle, Maide	on Sumame)	
/lan	and Mental P	To Be	IMSIR	Guler		3	min	e (un	know	$\cap$
laryla spells	yes I amus should be lied with to f health and Mental Hygiene. If item 27 is marked obtain then or other traumatic event, the M		19a. Informant's Name/Relationship	(Type, Print)		ddress (Street and Nur	nber or Rura	Route Number, City	or Town, State, Z	ip Code)
, S & C.	Health Health Iem 27		HSIM HRIT 20a. Method of Disposition	er.	Place of Disposition	n (Name of	wol	10, FREC	ELAND Location - City or 1	MD 21053
To no	nent of h		1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, cremato	ry or other place)		A 1 =		
$\mathcal{A}_{\mathcal{M}}$	: 돈 만 글 .		*4 □Donation 5 □Other (Spec 21. Signature of Funeral Service Lic		22. Na	me and Address of Fa	- 2-6	-04 FO	KGSI H	ILL, MO
ä	Depa Impo eny le		Kimberly	1/ Zuviota	4 AFOC	me and Address of Fa 2325 Y EFULALTE	RIVA	TIVES FUI	UGRALCH	LAREL
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the dealy one cause on each line.	th Do not enter th	e mode of dying, such	as cardiac or	respiratory arrest,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	MYOCA	RDIAL	INFAR	CTI	ON		Onset and Death
	/Medical Examiner		resulting in death)	Due lo (or as a conse	guence of):	ARTERY	0	ISE AC	c	
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec			10	1-6113	و	
(X) = 0	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	C.						
76057	ysicien and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):					
	0 0	dical		d						
vision of Vital Records, P.O. Box 68	attending physic	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feti					23d. Date of delik	very
P.O. Box	ed by the attendir detached for use	sicia	in the past 12 menths? 1 □ Yes 2. ■ No 9 □ Unknown	4☐Pregnant all time of a		opic pregnancy ner (specify)			Month	Day Year
<b>G</b> .	ed by detac	y Ph	Part II. Other significant conditions	contributing to death but not re-	sulting in the under	lying cause given in Pa	rt I.	23e. Did tobacco	use contribute to	the cause of death?
ords	been sign should be	ed b						1 🗆 Yes	2 □ No 3 □ Pro	obabiy 4 dunknown
eco	has been ge 2 shoul	Completed						24a. Was an autopsy	24b. Were aut	topsy findings available
E B	cate ha	Соп						performed? 1 ☐ Yes 2 🖼 N	death?	2 □ No
Vita	certificate rector. pag	Be	25. Was case referred to medical examiner?	Hospital:		Other		(Check only one)		
o J	or this eral di	. To	1 XYes 2 No 27. Manner of Dealh	28a. Date of Injury	28b. Time of	28c. Injury at		ie 5 Residence 8d. Describe how inj		ify)
ion	death. ctor: After y the funer	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day Yeer)	Injury	Work? U 1 ☐ Yes 2	□No			
Division of Vital Records,	a after de	Certification:	3 ☐ Suicide 6 ☐ Could not determine		nome, farm, street,	factory, office	2	8f. Location (Street a City or Town, Sta	and Number or Rui te)	ral Route Number,
H Os D S D	within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	ledical (	29a. Certifier (Check only-one)  1 Certifying F	Physician: To the best of my known aminer: On the basis of examination and manner stated.	owledge, death occation and/or investi	curred at the time, date gation, in my opinion, d	and place, a leath occurre	nd due to the cause( d at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	within 2 To the complet	Me	29b. Signatule and title of certifier	7		29c. License numbe	_	29d. D	ate signed (Month,	
	M	1	Chamelseo,	from MA		D 383	6 5	2	005   2	4
	/		30. Name and address of person wh	o completed cause of death (Item RASSO MD 6	m 23a) (Type, Prin	CHARL	es s-	r TOWS	000	
	Sta Registr		31. Date filed (Month, Day, Year) FFR 0 9 2004	32. Registrar's Sign.	ature					

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan		nent of Health and cate of Death	Mental Hygie	ne No. 2004	03479
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Lass 4a. Fecility Name (If not institution, give	ine Alex	46	City, Town, or Location of Deat	2. Date of Death Month February	Day Year 4,2004	3. Time of Death 1:57 P M
	Examin Funeral Director	er	Greater Baltimore 5. Social Security Number 6. S 218-310-0968	Medical Cente	last birthday) If	OWSON Under 1 Year If Under 24 Hrs onths Days Hours Min.	8. Date of Birth (Month, Day, Ye	Baltimore 9. Birthr	place (State or Foreign my)
	death with the Maryland ms 23a or 28a-f show f must be redified at	ector	Usual Residence of Decedent  10a. State 10b. County  10e. Street and Number	10c. Cit	y, Town or Location	ETTS VILLI	E 10a.	Citizen of What Cour	10d. Inside City Limits 1 Yes 2 No
D036	5 E E	by Funeral Director	0 01 1	12. Was Decedent Ever in U. Amed Forces? 1   Yes 2 PNo If Yes, Give Year or Dates:	S. 13. Was	21084 Decedent of Hispanic Origin? (S., specify Cuban, Mexican, Puerl (es. 21 No. Specify:		14. Race - Americ Black, White,	can Indian,
215-	permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or any injury or other traumatic event. The Medical Exempone.	Completed b	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	16a. Decedent' (Give kind life. DO		rking (.	o. Kind of Business/In	
ALEX, Marce e, Maryland 21215	should be fill and Mental Hy smarked oth numatic event	To Be	17. Father's Name (First, Middle, Last) Theodore F. 19a. Informant's Name/Relationship (	Foti	19b. Mailing A	18. Mother's Nai	ne (First, Middle, Maid SBPC) Iral Route Number, Ci	slin	Code) 210 84
$A_{\parallel}$	Pages 1 and 2 lent of Health and 1: If Item 27 I		KCDC+6: AIC  20a. Method of Disposition  1 (Burial 2 Cremation 3 C  4 Donation 5 Other (Specific	Removal from State	Place of Disposition emetery, cremato	Mid Summer (Name of y or other place)	Date 200	LETTOVILLE Location - City or To	DE MO
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licer  William  23a. Part 1. Enter the disease, or com.	pleations that caused the death	22. Na V= V.A.	me and Address of Facility BA US FUNELAL ( e mode of dying, such as cardia	HAPEL , 88	MD 212	Approximate
	Physician /Medical Examiner		shock, or heart failtire. List only, Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	valvy f	Failure			Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t					
.O. Box 6	that the death certifica ed by the attending ph detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of di	I death 3 ☐ Ect	opic pregnancy er (specify)		23d. Date of delive Month	ery Day Year
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions of	e			23e. Did tobacc	co use contribute to the	1
al Reco	sicien: The law r certificate has be rector, page 2 sh	Completed		NOIR V	NFMC		24a. Was an autopsy performed 1 Yes 2	prior to co	psy findings available mpletion of cause of
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Certification; To Be	25. Was case referred to medical examiner?  1  Yes 2  Oo   27. Manner of Death 1  Accident	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	DOA Other: 4 Nursing F	ath (Check only one) tome 5 Residence 28d. Describe how in		y)
Divis	spital or Attend ours after death naral Director: , filled in by the f		3 Suicide 6 Could not be determined	building, etc. (Specify	y)		City or Town, S		· · · · · · · · · · · · · · · · · · ·
	To the Hospital or A within 24 hours after To the Funaral Direction Completely filled in b.	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	niner: On the basis of examina and manner stated.	tion and/or investi	29c. License number	29d.	Date signed (Month,	Day, Year)
	Sta Registr		30. Name and address of person who 31. Date filed (Month, Day, Year)  FER 0.9.201	SCHUM 32. Registrar's Signa	MIN	D-44728	J. Charl	ost Ta	USIN MY

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland /	Department of F		ental Hygien	/11114	03480
	Physici /Medio		1. Decedent's Name (First, Middle, La	D. ARROWOOD			2. Date of Death	ay 7,2004	3. Time of Death
	Examir		4a. Facility Name (If not institution, give	uale itospi	1 ( // /	Pr Location of Death	14	BOLTIN	nore
	Funeral Director		5. Social Security Number 6. S 243-38-2/48  Usual Residence of Decedent	Sex 7. Age (In yrs. last to 86	oirthday) If Under 1 Year Months Days		8. Date of Birth Month, Day, Year	9. Birthpl Count	ace (State or Foreign
	ith the Maryland or 28e-f show to notified at	tor	10a. State 10b. County	10c. City, To	wn or Location  Perry H	AI		10	Od. Inside City Limits
	death with the Maryland rms 23a or 28e-f show	il Director	10e. Street and Number	ERMAN CI	10f. Zip Code	1236	10g. C	itizen of What Count	•
36	rs after death with the Maryla I', or Items 23a or 28e-f shor xaminer must be natified at	by Funeral	11. Marital Status  1 Never Married 2 Married  2 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 Pres 2 No U.S. If Yes, Give Year or Dates: ARMY	13. Was Decedent of H If Yes, specify Cuba 1  Yes 2 No		rify Yes or No- ican, etc.)	14. Race - America Black, White, e	an Indian,
1215-00	within 72 hou sne. than "natura ne Wedical E	Completed	15. Decedent's E (Specify only highest grant Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working	g	Kind of Business/Ind	
AROWOOD RUTUS altimore, Maryland 21215-0036	be filed tal Hygie d other	To Be Co	17. Father's Name (First, Middle, Last Robert ARROW		DaRSENT		(First, Middle, Maide		
10 OC Mary	1 and 2 should Health and Men tem 27 is marke		19a. Informant's Name/Relationship		b. Mailing Address (Street	and Number or Rural	0	or Town, State, Zip (	
RON more,	Pages 1 a lent of Hea nt: If item ry or othe		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Special	20b. Place cemet	of Disposition (Name of ery, crematory or other place	Da Da	te 20c. L	ocation - City or Tov	
ARBalti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lice	11:42	22. Name and Addre	ss of Facility STell	A FUNERAL I	tome CHTD	
	Physician /Medical Examiner		23a. Part. Enter the disease, or com- sh.ck, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	erios certic	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
20		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence					
58760,	ficate be ex physician s the burial	cai	Todding in dealify East	Due to (or as a consequence	9 of):				
Division of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed ar death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	th 3 Ectopic pregnancy 5 Other (specify)	,		23d. Date of deliver Month	y Day Year
rds, P	w requires that been signed to should be det	by	Part II. Other significant conditions of	contributing to death but not resulting	in the underlying cause give	en in Part I.		use contribute to the	o cause of death?
II Reco	: The law re cate has bee page 2 sho	Completed					24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No.	prior to com death?	sy findings available pletion of cause of
f Vita	Phyaician: The this certificate ha	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Oth	26. Place of Death ( er: 4 ☐ Nursing Home	The state of the s	6 ☐Other (Specify)	
sion o	ttending Ph death. ctor: After th y the funeral	Certification:	27. Manufer of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)		Yes 2 □No	d. Describe how inju		
Divi	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certifi	4 Homicide determined	building, etc. (Specify)		ļ	City or Town, Stat		
	the Hosp hin 24 ho the Fune npletely fi	ledical	one)	nysician: To the best of my knowledg niner: On the basis of examination a and manner stated.	novor investigation, in my of	pinion, death occurred	d due to the cause(s I at the time, date an	s) and manner as sta d place, and due to t	ted. he cause(s)
	with To T	Σ	29b. Signature and title of certifier	22	29c. License		29d. Da	ate signed (Month, D	1, 2004
_	20		30. Name and address of person who	completed cause of death (Item 23a)		10 - Paltin	NO Magu	101/1/2127	7
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	And de	7	or Christian	1000 -122	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEB. 2004 MARY BOLEWSKI 10:59 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF CATONSVILLE CATONSVILLE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗵 F MARYLAND 92 214-20-5045 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 714 S. PORT STREET 21224 USA tiled within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be til Iment of Health and Mental H tant: If item 27 is marked oth jury or other traumatic even KAROL OWSIENIESKI ANNA STRASINSKA ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. MARYANNA CIEPIELA 6231 OLD WASHINGTON RD. ELKRIDGE, MD. 21075 20b. Place of Disposition (Name of Date 20a Method of Disposition 20c. Location - City or Town, State cometery, crematory or other place)
STANISLAUS 1 ■ Buriai 2 Cremation 3 Removal from State Department of Important: If any injury or once. 2/4/04 BALTIMORE, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lic KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA Pnysician /Medical Due to (or as a consequence of): Examiner EREBROU AS CUL AR DAY ACCIDENT Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician sthe burial Physician/Medical anding pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 TYes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ပ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident thours after death uneral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide within 24 hours a Hospital cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only one) o the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEB 2nd 2004 10053150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIVER RID BALTIMORE ZIZZI 201-109 BACK GUPTA SUARE NIMALA 31. Date filed (Month, Day, Year); \*\* \* 32. Registrar's Sinature State Registrar

			1 - For Stete Registrer	State of Ma	aryland		artment <i>rtificate</i>				•	giene Reg. No.	-20	04	03	482
is a	Physici /Medic		1. Decedent's Name (First, Middle, Last,								2. Date of Dea	ath Day		Year	3. Time	
خمر	Examir Funeral	ner	4a. Facility Name (If not institution, give	- Medical	Centre (In yrs. la			tim			8. Date of Birt		County		=	or Foreign
	Director			M 2□F	78	Yrs.	Months	Days	Hours	Min.	(Month, Da)	y, Year)		Coun	MD	or roraign
	e-f ehow	tor	MD BALTIMOR	E		Town or Lo ER ST	cation ATION							1	0d. Inside	City Limits s 2 □ No
10.1	23a or 28	Funeral Director	10e. Street and Number  108 FLEMING DRIVE				10f. Zip	Code 1222				10g. Citi	zen of W	/hat Coun	try?	
5-UU36	eturel', or Itams 23a or 28e-f ebo ical Exertiber rest be notified at	þ		12. Was Decedent i Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:				ent of Hi ify Cubai	spanic Ori n, Mexican Specify:	gin? (Spec n, Puerto R	cify Yes or No- lican, etc.)	1	14. Race Black	- Americ c, White, c	etc.	
2	than than	Completed	15. Decedent's Edu (Specify only highest grade	cation		(Give life.	dent's Usual kind of work DO NOT use NICIA	k done d e retired)	urina mos	t of workin	g		nd of Bu	siness/Ind	ustry	
Maryland Z	d ai	To Be Co	17. Father's Name (First, Middle, Last) THOMAS BURMA	N						or's Name	(First, Middle,					
֓֞֞֞֜֞֞֜֞֜֞֜֞֜֞֓֓֓֓֓֞֜֜֜֓֓֓֓֓֓֓֓֓֓֓֓֓֜֟֜֓֓֓֓֓֓֜֟֜֓֓֓֓֓֡֓֜֝֡֓֡֓֜֡֡֓֜֝֡֡֡֓֜֡֓֡֡֡֜֝	of Health and item 27 is m		19a. Informant's Name/Relationship (Ty MYRTLE BURMAN/WIFE 20a. Method of Disposition 1 ☑ Surial 2 □ Cremation 3 □ R		сеп	108 be of Disponetery, crem	FLEMII	NG D e of her place	RIVE,	, BAL <sup>c</sup>		20c. Loc	222 cation - 0	City or To	vn, State	
Dallinore,	Department of mportent: if any injury or once.		14 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Mut	in CROW	22	LE VE' 2. Name and 701 L	Addres	of Facilit	y JA	/2004 ( MES A. ALTIMOR	MOR'	TON	& SOI	MD NS F.	H. IN
	physician and Wales (Wadical xamine burial-transit set the burial-transit and the burial-tr	dicai Examiner	23a. Party Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a conseque	nce of):									Approxima Interval Be Onset and	tween
The law requires that the death certifies	igned by the attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 Live birth 3ct 4 Pregnant at 9 Unknown	2 🗆 Fetel de	eath 3	Ectopic pre					2	3d. Date Mont	of deliver	,	Year
ouires that	been signed by	ed by Ph	Part II. Other significant conditions con	tributing to death bu	scase	ng in the ur	nderlying car	use give	Λ.	ingsm	23e. Did tol	bacco us		oute to the		death? Unknown
	certificate has been rector, page 2 shoul	Completed by							-		24a. Was a autops perform	sy	de	or to com ath?	sy findings pletion of c	available cause of
To the Hospital or Attending Physician: The law requires	within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  H  27. Manner of Death Shatural 5 Pending investigation	ospital: 1 Inpatier 28a. Date of Injun (Month, Day	y 28	VOutpatient Bb. Time of Injury		Other c. Injury Work	: 4 □ Nur	sing Home	Check only on 5  Reside d. Describe ho	ence 6				
vital or Atte	hours after death. uneral Director: A ily filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc.	. (Specify)						f. Location (St City or Town	n, State)				nber,
the Hose	within 24 hours  To the Funeral completely filled	Medical	29a. Certifier (Check only one)  Check only one)  Check only one)  Check only one)  Check only one one of the certifier	icien: To the best of er: On the basis of and manner stat	examination	edge, death and/or inv	estigation, ii	the time n my opi	nion, death	l place, and h occurred	at the time, da	ate and p	olace, an	t of eub b	he cause(s	5)
. 2	1	-	19	nnloted cours of	oth /ha = 5	na) (T			714		2		0S	Month, D.	004 004	
	Star	te ar	30. Name and address of person who con Lichard Table 31. Date filed (Month, Day, Year)	32. Registral	Bayrie	Medical		4941	) Eni	to d	luence, B	~iHu	e, N	10 2	1224	

	1 - For State of Maryland / Registrar	Department of Health and N Certificate of Death	Mental Hygiene 2 0 0	4 03483
Physician /Medica	Danies Elliaset Baron		2. Date of Death February 6, 2004	3. Time of Death 4:33 p M
Examine	a man of the same	4b. City, Town, or Location of Death TOWSON	4c. County of De Baltim	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		intholece (State or Foreign Country) aryland
aryland show	NO Delliment De	wn or Location ckville		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
vith the Mar or 28a-f si	10e. Street and Number	10f. Zip Code	10g. Citizen of What 0	Country?
urs after death v al', or items 23s range must	8800 Walther Blvd  11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 3 Narried 1 Never Married 4 Divorced 1 Narried 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 1 Never Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 1 Never Mar	21234  13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.) 14. Race - An Black, Wh	
ed within 72 ho ygiene. her than "naturi t, the Medical	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  AS	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use relified) sistant Professor of Medica lustration	Johns Hopkins	
Mental Hy Mental Hy arked otherstic event.	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Sumame) COX	
alth and 2 sho	19a. Informant's Name/Relationship (Type, Print)	ob. Mailing Address (Street and Number or Rui 420 Oak White Road, Notti		, Zip Code)
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ed once.	20a. Method of Disposition  1  Burial 2 XXCremation 3  Removal from State  1  Donation 5 Other (Specify)	of Disposition (Name of ery, crematory or other place)  O Service Corp. 2/10/0	Date 20c. Location - City of Towson, MD	or Town, State
permit. Departri	21. Signature of Funeral Service Licensee William G. Dau	22. Name and Address of Facility Leo		neral Home
Physician /Medical	23a. Pert1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each tine.  Immediate Cause (Final disease or condition resulting in death)	o not enter the mode of dying, such as cardiac ST CANCER	or respiratory arrest,	Approximate Interval Between Onset and Death
cate be executed  physicien and ithe burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Universe or iripiny that initiated events resulting in death) Last  Due to (or as a consequence	e of):		
Physicien: The law requires that the death certificate be executed in this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transition.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	th 3 Ectopic pregnancy 5 Other (specify)	23d. Date of d Month	elivery Day Year
uires that I n signed by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 No 3 ☐ I	to the cause of death?  Probably 4 □Unknown
The law requir			24a. Was an autopsy prior to death?  1 Yes 2 No 1 Yes	
To the Hypitel or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	1 Yes 2 No Hospital: 1 Inpatient 2 EP/C	Othor	th (Check only one) ome 5 ☐ Residence 6 █️☐Other (Sp 28d. Describe how injury occurred	recity) to spice
Horpitel or Attending 4 hours after death. Funeral Director: After tely filled in by the fune	27. Manner of Death  1 X Natural  2 \( \text{Accident} \)  3 \( \text{Suicide} \)  4 \( \text{Homicide} \)  4 \( \text{Homicide} \)  28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street and Number or I City or Town, State)	Rural Route Number,
Te Hounge Te Funera Hetely fills	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledd 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the cause(s) and manner ared at the time, date and place, and di	as stated. ue to the cause(s)
To the comple	29b. Signature and title   certifier	29c. License number 1) 25 205	29d. Date signed (Moi	nth, Day, Year)
12	30. Name and address overs who completed cause of death (Item 23a	(Type, Print)	Februmy Si. Etc. Ma	21201
State Registra	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

4/33 P.M.

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FEBRUARY

	1 - State	State of M		epartment Certificate		h and Mental I	/	2006	031.81
	Registrar  1. Decedent's Name (Fir	st, Middle, Last)		Certificate	or Dea	2. Date of			3. Time of Death
Physician	1401 6111	Andrew E	Beumer			- Month	Day	2004	12:05 PM
/Medical Examiner	4a. Facility Name (If not	institution, give street and number	)	4b. City, T	own, or Locati		4c. Co	unty of Deeth	
	5. Social Security Number	U(111 105) LL (1) LI er 6. Sex 7. A	ge (In yrs. last bin	thday) If Under 1	Year If Un	der 24 Hrs. 8. Date o	DOL Birth	LT MOV	
Funeral Director	400-38-3107	1 M 2 □ F			Days Hou	rs Min. December	f Birth Day Year) 2° 15°, 193	30 Kenti	place (State or Foreign ntry) UCKY
p s	Usual Residence of Dec	edent b. County	10c. City, Town	or Location				1.	10d. Inside City Limits
death with the Maryland ms 23a or 28a-f ehow rmust be notified at		Baltimore	-	rlea					1 ☐ Yes 2X No
with the Mau a or 28a-f el be notified	10e. Street and Number			10f. Zip (	Code		10g. Citizer	of What Cour	ntry?
23a c	25 West Elm	Avenue			21206		USA		
Sifter death virtems 23e nitter must	11. Marital Status 1 □ Never Married	12. Was Decedent Armed Forces 1 X Yes 2	? 140 170	13. Was Decede If Yes, specif	ent of Hispanic by Cuban, Mex	: Origin? (Specify Yes o cican, Puerto Rican, etc		Race - Americ Black, White,	
036 uurs aff	3 ☐ Widowed 4 ☐	If Yas, Give		1 ☐ Yes 2	<b>©</b> No <i>Spe</i>	city:	Sp	ecity: Whit	te
l 21215-00 led within 72 hou tygiene. her then "netura ht, the Modelle At. Completed	15. (Specify or	Decedent's Education  nly highest grade completed)	16a.	Decedent's Usual (Give kind of work	done durina i	most of working	16b. Kind	of Business/In	dustry
within see.	Elementary/Secondary	y (0-12) College (1-4or <b>n/a</b>	5+) Bur	eau of Fina	,	icer	Baltin	nore Cour	nty Government
ind 2 be filed tal Hygi d other	17. Father's Name (First	, Middle, Last)			18. M	other's Name (First, Mi	ddle, Maiden Su	mame)	•
Vlar Vlar Menta arked attc.	Emil Ed	lward Beumer				Elizabeth		mi th	
Mar Mar Mar d 2 sh th and 7 is m traum	Anna Beumer-wi	Relationship (Type, Print)				mberor Rural Route No Baltimore, M		wn, State, Zip	Code)
re, land thealitem 2	20a. Method of Disposition	on	20b. Place of	Disposition (Name y, crematory or oth		Date	_	ion - City or To	own, State
Imo Page: nent o	1 Ø Burial 2 ☐ Cre 1 4 ☐ Donation 5 ☐	emation 3 Removal from State Other (Specify)	'Sacred H	eart of Jes	SUS	2/11/04	Dunda	lk, MD	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 ehow eny injury or other traumatic event, the Modeal Examiner must be multilised at once.	21. Signature of Funeral	Service Licensee William	G. Dau	22. Name and 5305		acility Leonard (	J. Ruck, I e, MD 212		eral Home
(7)	23a. Pert1. Enter the dis shock, or heart fail	sease, or complications that cause ure. List only one cause on each	ed the death. Do r	not enter the mode	of dying, such	as cardiac or respirato	ry arrest,		Approximate Interval Between
Physician	Immediate Cause (Final disease or condition resulting in death)	a. Acute 1	YI						Onset and Death
/Medical Examiner	resulting an death)	Due to (or as	s a consequence	of):					
	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury)	ons, b. Due to (or as	s a consequence	of):			<del></del>		
executed in and inal-transit	Cause (Disease or injury that initiated events resulting in death) Last	C		- 0					
8760, cate be executed physicien and the burial-transit		Due to (or as	s a consequence of	Jr):					
6876( tificate be by physicie as the bur		d.							
	IF FEMALE: 23b. Was decedent prec		e of pregnancy 2  Fetal death	3 □Ectopic pre	gnancy		23d	. Date of delive	. /
O 8 8 8 18	in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death	5 Other (spec	cify)		_ 11	Month	Day Year
s that if	Part II. Other significant	t conditions contributing to death	but not resulting in	the underlying car	use given in Pa	art I. 23e. [	Did tobacco use	contribute to th	he cause of death?
Cords, w requires been sign should be							ØYes 2□N	lo 3 Prob	oably 4 Unknown
al Record  The law requir cate has been s page 2 should						a	Vas an 2 utopsy	4b. Were auto	opsy findings available mpletion of cause of
al H						1 □ Y	erformed? es 2 No	death?	2 No
of Vita hysician his certifi il director		Hospital: 1 Inpati	ient 2 PER/Ou	tpatient 3□ DQA	Othor	lace of Death (Check of Nursing Home 5 F		Other (Specif	
n of ng Phy ther thi neral c	27. Manner of Death	28a. Date of Inj Pending (Month, Da			c. Injury at Work?		ibe how injury or		y/
Sion tandir for: Al the fu	2 Accident	investigation		М	1 Yes 2				
Division c tal or Attanding P rs after death. al Director: After t ed in by the funers	4 Homicide	determined 286. Place of in building, e	njury - At home, fa etc. <i>(Specify)</i>	rm, street, tactory,	office	City or	Town, State)	umber or Rura	al Route Number,
		Certifying Physician: To the best Medical Examiner: On the basis of	t of my knowledge	, death occurred at	t the time, date	and place, and due to	the cause(s) and	d manner as st	tated.
To the Hosp within 24 hou within 24 hou completely fill	one) 29b. Signature and title	and mannars	tated.		License numb			igned (Month,	
F 3 F 3	Dos. Signators and title	( nekl /	MD	7	> < < 5	785	2 /	7/8 W	-my, 1041/
7+1	30. Name and address of	of person who completed cause of	death (Item 23a) (	Type, Print)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	2		1/0	
1	31. Date filed (Month, Da	14/11/ Square by	trar's Signature	altmore	IVId	11231			
State Registrar		0 9 2004	e M	books	NA		_		

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). Box 68760,	
P.O	
l Records,	
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Division of	

		n Black Indelible ink. Assure A land / Department of Health and I	
Physician	1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 2004 U3485  2. Date of Death Month, Dey Year  3. Time of Death
/Medical	GORDON R	BURMeister	FeB 5 2004 850AM
Examiner	4e Eccility Neme (If not institution, give street and number)  DAH' MURE VA MEd'CAL (	4b. City, Town, or t	
Funeral	5. Sociel Security Number 6. Sex, 7. Age (In	yrs. lest birthdey) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Foreign
Director	217-07-1179 12M 2□F 8L Usuel Residence of Decedent	Yrs. Months Deys Hours Min.	8. Date of Birth (Month, Day, Yeer) APK   1919   Maryland
show der		c. City, Town or Location	10d. Inside City Limits
vith the Mei t or 28a-f si be notified Director	Maryland Baltimore	Edgeme	
ath with the Meryler 123s or 28s-f show 1st De notified at 1st Director	10e. Street end Number 7833 Denton Avenue	10f. Zip Code 21219	10g. Citizen of Whet Country? United States
Maryland 21215-0020 d 2 should be filed within 72 hours efter death with the Meryland th end Mentel Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Maritel Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates: 19	in U,S. 13. Was Decedent of Hispenic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 41-45	pecify Yes or No- o Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
5-0 72 ho natur	15. Decedent's Education (Specify only highest grede completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business/Industry
1 21215-0 ed within 72 ho ygiene. Ner than "naturi ft, the Medical Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired) Fir	e Veterans
d 2	12 Years 17 Fether's Neme (First, Middle, Last)	Chief of Police & Dep	t. Administration e (First, Middle, Maiden Sumame)
d be fill some of the cover	Frederick Burmeister	Anna	
aryla should the marked umeric	19a. Informant's Name/Relationship (Type, Print) Son		ral Route Number, City or Town, State, Zip Code)
	Gordon Russell Burmeister,		
or Heal		Ob. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location · City or Town, State
Pages Pages ment of 1 ant: If 1k	XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Meadowridge Mem. Park Cem	. 2/9/2004 Dorsey, MD
Baltimore, pemit. Pages 1 ar Department of Hear important: If Hear; any injury or other	21. Signature of Funeral Service Licenses	22. Name and Address of Facility Duda-Ruck Funeral 7922 Wise Ave. Du	Home of Dundalk, Inc.
	23a. P. 11. Enter the disease complications that caused the connock, or heart failure. List only one cause on each line.		
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	na Cancer	or respiretory arrest, Approximate Interval Between Onset and Death
A 6 9	Due t	to (or) as a consequence of):	
BOX 68/60, seth certificate be executed ettending physicien end for use as the buriel-trensit clan/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c	o (or as a consequence of):	
cords, P.O. Box 687 requires that the death cartificate seen signed by the ettending phys ahould be deteched for use as the eted by Physician/Medic	d		
P.O.	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?  1 ★ Yes 2 □ No 3 □ Probably 4 □ Unknown
S, F gned be de by P			The Tallow of House, 45 children
D > 20 -=			24a. Was en autopsy performed?  24b. Were autopsy findings available prior to completion of cause of deeth?
The law ate has to page 2 s			1 ☐ Yes 2 No 1 ☐ Yes 2 No
VITAI KE  vicien: The lav  certificate has rector, page 2  Be Comp	25. Was case referred to medical examiner?		(Check only one)
Physic this cal direction			me 5 ☐ Residence 6 ☐ Other (Specify)
dling I	1 Natural 5 Pending (Month, Dey Year	r) 28b. Time of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how injury occurred
DIVISION OF VITA tal or Attending Physician: rs after death. al Director: After this certific led in by the funeral director.  Certification: To Be (	3 Suicide 6 Could not be	At home, farm, street, factory, office	28f. Location (Street end Number or Rural Route Number, City or Town, State)
DIVISION OF VITAL Heel To the Hospital or Attanding Physicien: The law within 24 hours effer deeth.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  Medical Certification: To Be Comp	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my in the property of	knowledge, death occurred at the time, date and place, innetion end/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier  May Sawal 7 MD	29c. License number	29d. Date signed (Month, Day, Year) Feb 5 2004
8+1	30. Neme end eddress of person who completed cause of deeth (I	gneture	leet Baltimule MD 21201
State	31. Dete filed (Month, Day, Year) 32. Registrer's 9	gneture	
Registrar DHMH 16 Rev 6/95	FEB 0 9 200 A	Alus II famile	

27939

Blizzard

Alice

4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Easton, Maryland Tal

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

Hooths Days Hours Min. Dec 22, 1941 Genesis Eldercare The Pines Talbot 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1□M 2⊠F 62 Director 212-40-9797 Usual Residence of Decedent desth with the Meryland 10a, State 10b. County 10c. City, Town or Location r than "neturel", or Iteme 23s or 28s-f ahow the Medical Examiner must be notified at Director MD Talbot Easton 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 610 Dutchman Lane 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married kimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>۾</u> 3 ☐ Widowed 4 ĬĬDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lee Avery Waldron Dorothy Elizabeth Blades ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Heelth air Importent: If Item 27 Is eny Injury or other treus once. Lesley Jo Buchanan/daughter 4627 Cedar Place Preston, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Neumania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due (or es a consequence of): Examine ettending physicien end for use as the burief-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate hes autopsy ormad? 24 No 1 Yes al or Attending Physician: T sette deeth.
I Director: After this cerificated in by the funerel director, pa 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4K Nursing Home 5 Residence 6 Other (Specify) Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I complately filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. No. Z U

Day

2004

5:18 P M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

Month

1 ☐ Yes 2√ No

Maryland

white

22,

2. Date of Death Month

Jan.

1- Forthend Items 24a,25,26,27,29a per Dr.,6828,77,090 Vidio Certificate of Death

1. Decedent's Name (First, Middle, Last)

Mary Alice Blizzard

Physician

/Medical

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 9 2004

08

Tino

32. Registrar's Signature

		-	For State Registrar	State of Maryl		artment of Hertificate of D			ene 2001	03487
			1. Decedent's Neme (First, Middle, Last	)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Mary Evel	Lyn	Belt			February	,	5:15a M
	Examin		4e. Fecility Name (If not institution, give	street and number)		4b. City, Town, or I	Location of Death	-	4c. County of Dea	ath
	*		Charlestown Care			Catonsvi		O Date of Birth	Baltimo	
	Funeral		5. Social Security Number 6. Se	x	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, )		thplace (State or Foreign ountry)
e de	Director	}	212-09-9016 Usual Residence of Decedent	1 1				Oct. 6,	1907   Ma	aryland
	land		10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits
	Many e-f eh	ğ	Maryland Baltimon	re	Catonsvi	.11e				1 ☐ Yes 2 ☐ No
	or 28c	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	th wil	ai	707 Maiden Choice	Lane Apt.	7102	21228		Į	JSA	
	r dea	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of His f Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
3	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene debt than "natural", or iteme 23a or 28e-f ehow dother than "natural", or iteme 23a or 28e-f ehow event, I to Modical Examinar moral be notified at	ed b	15. Decedent's Edi		16a, Dece	dent's Usual Occupat	tion	10	3b. Kind of Business	/Industry
Ç	in 72	Completed	(Specify only highest grad		(Give	kind of work done du DO NOT use retired)	uring most of world	king		,
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-401 5+)	Lega	1 Secreta	rv		Attorney (	Office
פ	e filed al Hygi other vent, L	Bec	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma		
<u>lar</u>	should be and Mental marked o umatic eve	ToE	Peter	Tue1			Susan	L	Espe	ey
Baltimore, Maryland 21215-0036	and and sum	, 3	19a. Informant's Name/Relationship (7	*		ng Address (Street ar				
≥ ``	Health Health tem 27 other tra	1 00	Wilbur Belt (Son)			enue, Gam	betta-Ch			
0	Pages 1 nent of H int: If Ite		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	•	natory or other place		_	oc. Location - City of	
Ē	permit. Page Department of Important: If any injury or once.	1	* 4 □ Donation 5 □ Other (Specify			rk Cemete			altimore,	
<u>8</u>	Department of the property of		21. Signature of Funeral Service Licen		22	2. Name and Address			ore, MD 2	
	40244		23a. Part1. Eater the disease, or comp	lications that caused the	death. Do not ent					Approximate
8760,	Physician //Medical Examiner  The private transit tran	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor  Due to (or as a cor  Due to (or as a cor  Due to (or as a cor	nsequence of):	pitas.				Onset and Death
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
	quires that n signed b	by	Part II. Other significant conditions or	ontributing to death but no	t resulting in the u	nderlying cause give	n in Part I.	23e. Did toba		to the cause of death? Probably 4/20 Unknown
Division of Vital Records,	he law require e has been si age 2 should t	Completed						24a. Was an autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	th (Check only one)		22.110
>	Phyaici this cer al direc	To B	examiner? 1 □ Yes 240 No	Hospital: 1 Inpatient	2 ☐ ER/Outpatier	nt 3 DOA Other	r: 44 Nursing H	ome 5 Residen	ce 6 Other (Sp	ecify)
0	ng Ph ter th neral		27. Manner of Death  ↑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Injury Work	at ?	28d. Describe how	r injury occurred	
Visio	r Attending Physician: er death. rector: After this certifica by the funeral director, t	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, str		es 2 □No	28f. Location (Stre City or Town,		Rural Route Number,
۵	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical Cer	29a. Certifier Certifying Ph	vsician: To the best of my liner: On the basis of exa	/ knowledge, deat	h occurred at the time	e, date and place	, and due to the cau	use(s) and manner a	is stated.
	To the H within 24 To the Fi complete	ledi	one)	and manner stated.						
	To To COUT	Σ	29b. Signature and title of pertifier	/		29c. License	number -		d. Date signed (Mon	
7	17.			, wil		59	( ) 7 \ /		CAIM C'	
	10		30. Name and andress of person who	3 711	Mai		016	ave (9	fun 2, 2	ę
	Sta Registi		31. Date filed (Month, Day, Year) FFR 0 9 2004	32. Registrar's S	signature	Ale P				

State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** CHARLES BRADSHAW 3:15 P FEBRUARY 04 2004 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL CO. MARINER HEALTH OF GLEN BURNIE GLEN BURNIE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1MM 2□F February Maryland Director 215-18-4535 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b County 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hyglene.
Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Exercities Lives to exercitied an once. 1 ☐ Yes 2 No Directo Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 400 Marley Neck Blvd. 21060 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 質 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 U.S. Coastguard 0 Shipfitter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Unkown Charles H. Bradshaw Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Marley Neck Blvd, Glen Burnie, Maryland 21060 (Wife) Helen M. Bradshaw 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 02-09-04 Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Mary Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland 21122 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) PULMONAR CHRONIC Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth Day in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco-use contribute to the cause of death? Division of Vital Records, à 3 ☐ Probably 4 ☐ Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and 10 person who perpendicul Eathsquard death (Item 200) Cypar Print) A RITCHIE HIGHWAY, BALTIMORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar een 0.9 2004

DHMH 17 Rev 1/2001

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			For State	State of Mary		rtment of Health and	Mental Hygi	ene	031,89
			Registrar		Cer	tificate of Death		g. No.	00902
	Physic	ian	1. Decedent's Name (First, Middle, La			_	2. Date of Death Month	Day Year	3. Time of Death
	/Medi		HEIRA		RIGHT		FEBRUA	RY 02 200	04 12.08 AM
	Exami	ner	4a. Facility Name (If not institution, give		4 0 1770 :	4b. City, Town, or Location of Deat	th	4c. County of Dea	<b>j</b> h
				1	SPITAL	BALTIMORE		N	A
	Funeral			Gex 7. Age (//	n yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, 1	rear) Co	thplace (State or Foreign
	Director		315 - 68 - 3580 Usual Residence of Decedent		70 115.		March 5	1955	MD.
	land ow		10a. State 10b. County	10	c. City, Town or Loc	eation			10d. Inside City Limits
	Many f she	5	MA	Δ		'			1 2 Yes 2 □ No
	the I	ect	10e. Street and Number			ATI MORE		-	
	with Baor	ā	Car Qua	in RA		2 12 14	100	g. Citizen of What Co	ountry?
	death with the Maryland ms 23a or 28a-f show Imust be notified at	Funeral Director	11. Marital Status	12 Was Decedent Eve	rin II S 12 VA	/as Decedent of Historia Origina / 6		U·3,	<i>n</i> ,
4.	ltan Itan	5	1 Never Married Amarried	12. Was Decedent Eve Armed Forces?	1 III 0.3.	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerl	to Rican, etc.)	14. Race - Ame Black, White	
\_ 8	Irs al	þ	3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 No If Yes, Give Year or Dates:	1	Yes 2 No Specify:		Specify: 1	hite
王 3	G Z IZ I D-UUSO filed within 72 hours after Hygiene. Hygiene "natural", or file sht, the Madical Examina	ed	15. Decedent's E		16a, Decede	ent's Usual Occupation	16	5b. Kind of Business/	
5	D 7 un a	Completed	(Specify only highest gra	ade completed)	(Give k	rind of work done during most of wor O NOT use retired)	rking	D. KING OF BUSINESS	industry
	filed withi Hygiene. other then ent, the M	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Housewife		Home	
	Hyg other		17. Father's Name (First, Middle, Last,				me (First, Middle, Ma	1100	
۵ ر	INICITYICITO  d 2 should be file th and Mental Hy ty is marked oth treumatic avent	To Be	CAMITT DO	2005		WAND	0	,	
7	Shou M M M M M M M M M M M M M M M M M M M	-	19a. Informant's Name/Relationship (	Type. Print)	19h Mailing	Address (Street and Number or Ru		City on Town Chats 1	70-4-1
FZ	Desittifiere, Maryland ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "natural", or itams 23a or 28a-1 show any injury or other treumatic avent, the Madical Examinar must be notified at ange.		EDWARD BRIGI		100	ο		My or rown, state, 2	ip Code)
7 9	E, IN 1 and 1 Health Ism 27 Sthar tr		20a. Method of Disposition		Ob. Place of Dispos		-	c. Location - City or	Town State
W	Pages nent of h ant: if its		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crem	atory or other place)		C. Location - City or	rown, State
I :	rtant njury		4 □ Donation 5 □ Other (Specif		DAKLAWN	Cemetery	6104 1	30 (to. M.	
HELL	Daltimor permit. Pages Department of Important: If it any injury or o		21. Signature of Juneral Service Licer	Sie Sie		Name and Address of Facility  ARTLLY Miller - 5	tella Fun	recal itor	
		1 2	frame.	July		27 harford 141		MS 2173	4
			23a. Pay11. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not enter	the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition		ZKALET				Onset and Death
	/Medical		resulting in death)	Due to (or as a co		- (1)			
	Examiner		Sequentially list conditions	ACUTE	RENAL	- FAILURE			
00	A 0 =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):				
XX	ite be executed ysician and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· SEPSIS					
( )	O, C		resulting in death) Last	Due to (or as a co	nsequence of):				
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Division of Vital Records D.O. Boy 68	Attanding Physician: The law requires that the death certifical redeath.  r death.  ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IE EEN I						
2	endir use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr	regnancy			23d. Date of deliv	very
•	deal death	Ci	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time		ctopic pregnancy Other (specify)		Month	Day Year
C	by th	hys	9-☐ Unknown	9□ Unknown					
	wrequires that the death been signed by the atter should be detached for	γP	Part II. Other significant conditions of	ontributing to death but no	t resulting in the und	lerlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Ţ	quire an siç uld b	pa	ISCHEMIC C	ARDIOMY	OPATH	<u>Y</u>	1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
ç	s bee	olet	DIABETES M	ELLITUS			24a. Was an	24h Were aut	oney findinge available
ď	he ta	mc	<u> </u>	CARTIO			autopsy	prior to co	opsy findings available ompletion of cause of
<u></u>	in: T ifficat or, pë		25. Was case referred to medical				1 Yes 2	Mo 1 ☐ Yes	2 □ No
5	sicia cert irecto	o Be	examiner?	Hospital:		Oth	th (Check only one)		
Ť	r this	<u>و</u>	27. Manner of Death	1	2 ER/Outpatient 28b. Time of	3 DOA 4 Nursing Ho		e 6 □Other (Speci	ify)
2	ding h. Afte	힐	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) Injury	Work?	28d. Describe how i	njury occurred	
· o	ttan deat tor:	ica	3 Suicide 6 Could not be	-	At home form	M 1 Yes 2 No	201 1 12		
.≥	or A after after Direction by	Certification;	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sa	pecify)	it, factory, office	City or Town, S	t and Number or Run itate)	al Route Number,
_	pital	ŏ	29a. Certifier 1 Certifying Phy	rainiam. To the best of our	. harandada a dan N				
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one)	mior. On the basis of exal	rknowledge, death o mination and/or inve	occurred at the time, date and place, stigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	the thin to the mple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License number			
	F 3 F 8		( Raitou )	M.D.				Date signed (Month,	
	,		Capou Nunc			RES - 000	) FE	BRUARY	,02,2004
	10		30. Name and address of person who o			·			
	Ψ			DNDF 560		RAVEN BLVD .	BALTIN	10RE M	D 21239
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's S		/		/	
	- Hegistra	11	FEB 0 9 200	4 Deperson	19	South!			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month 2004 BETTY V. BOSLEY 11:22 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS TIMONIUM BALTIMORE If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, 6/17/ 7. Age (In vrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1□M 2XF MARYLAND 219-32-4151 68 Yrs. Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD BALTIMORE DUNDALK 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5 7320 BERKSHIRE RD. 21224 items 23a USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ⊠ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. pemit. Peges 1 end 2 should be filed within 72 hours eftar or Depertment of Health and Mentel Hygiene. Important: if Itam 27 la marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 UNION WORKER TEAMSTERS

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname)

SAMUEL PRESTON BOSLEY

BERTHA BOSLEY 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print) JODY BOSLEY

7320 BERKSHIRE RD. BALTIMORE, MD. 21224

20a. Method of Disposition

Be

Physician /Medical

Examiner

Physician/Medical Examiner

Completed by

Be

Certification: To

Medical

20b. Place of Disposition (Name of cemetery, crematory or other place) SACRED HEART CEME.

2/7/04 DUNDALK , MD.

20c. Location - City or Town, State

1 MBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

KACZOROWSKI FUNERAL HOME P.A.

1201 DUNDALK AVE. BALTIMORE, MD.

21. Signature of Funeral Service Licenses

23a. Part1. Enter the disease, or explications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List of one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of) Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

26. Place of Death (Check only one)

1 ☐ Yes 2 No

25. Was case referre examiner?	ed to medical
1 ☐ Yes 2 📉 N	40
27. Manner of Deeth	
1 Natural	5 Pending investig
2 Accident	investig

3 ☐ Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

Division of Vital Records, P.O. Box 68760,

FEBRUARY

BETTY BOSLEY

or Attanding Physician: The lew requiras thet the death certificate be executed

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after death.

Hospital

within 24 hours after death To the Funeral Director: / completaly filled in by tha

			For State Registrar	State of	of Marylar		artmen rtificate				lental Hy	giene Reg. No.	104	03491
	Physici		Decedent's Name (First, Middle, La  TANY	•			BENDI	Т			2. Date of De Month	Day  ○   >	Year 2004	3. Time of Death
4	/Medio Examin		4a. Fecility Name (If not institution, giv		ımber)	4b. City, Town, or Location ol Death							ty of Death	
			LEVINDALE HEBREW		7 4 4	fried to a		BALTIMORE Inder 1 Year I If Under 24 Hrs. 8. Date of Birth					T 0 P: #	N/A
H	Funeral Director		5. Social Security Number 130-03-5945	ex □M 2∏ F	7. Age (In yrs.	88 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da MAR . 15	1915	9. Birthp	plece (State or Foreign intry) RUSSIA
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						· .	10d. Inside City Limits
	Maryia	tor	MD N/A			BALT	IMORE							1 ☐ Yes 2 ☐ No
	ier death with the Marylan Iteme 23s or 28s-f ehow Lef must be notified at	Director	10e. Street and Number				10f. Zip	Code			and the state of t	10g. Citizen of		
	eath w	Funeral	3 KENWOOD ROAD	12. Was Dec							o- 14. Ra	ica - Americ	U.S.A.	
9	72 hours after death with the Maryland neturel; or Iteme 23e or 28e-f ehow disal Evantiset ment be notified at		1 Never Married 2 Married	Armed F	orces? 2 [█No	ĺ	If Yes, spec 1 ☐ Yes 2		n, Mexicar Specify:		Rican, etc.)	Speci	ack, White,	, etc. WHITE
9	2 hours eturel', cal Eva	ed by	3 XWidowed 4 ☐ Divorced  15. Decedent's E	Year or I	Dates:		dent's Usua	^				16b. Kind of B		
215		Completed	(Specify only highest gr. Elementary/Secondary (0-12)	ide completed,	(1-4or 5+)	(Give	kind of wor DO NOT us	rk done d	during mos	t of work	ing			·
121	77 77 7		17. Father's Name (First, Middle, Last	)		OWNE	.R		18. Mothe	er's Name	e (First, Middle	CLOTHI Maiden Suma		ORE
Maryland 21215-0036	2	To Be	MOSHE			JACC	ВІ			HEL			ŕ	BERLIN
Mar	12 sh h and 7 le m traum		19a. Informant's Name/Relationship ( EMILE BENDIT /	•								er, City or Town MD 2121		o Code)
	of Health of Health f Item 27 r other tr		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 E		20b. [	Place of Disponentery, crea	a management of the same	the second of the second			The state of the s	20c. Location		own, State
Baltimore,	permit. Pages Department of Importent: If it eny injury or o		* 4 ☐ Donation 5 ☐ Other (Special	ý)	KIN	IG DAVI					2004	FALLS		
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			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that one cause on	caused the deat									Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. De	ment	ماحت								Onset and Doam
	Examiner		Sequentially list conditions	b	(or as a consec	(uerice or).							7	
7	ed set	ulner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
ó	ate be executed sysician and he burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):								
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Вох 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant		itcome ol pregn		76					23d. D	ate of delive	ery
.O. B	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown		birth 2 ☐ Feta nant at time of c nown		∃Ectopic pr ∃ Other (sp					М	lonth	Day Year
<u>α</u>	es that tigned by	by Ph	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	inderlying c	ause give	en in Part I		23e. Did		itribute to t	the cause of death?
ord	w require been sig should b	ted t	segme D	isord	4			<del></del>			10	Yes 2.XNo	3 🗌 Prot	bably 4 Unknown
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Vital		Be Co	25. Was case referred to medical						26. Place	of Deat	1. Yes		1 🗆 Yes	2) No
of V	N 20	2	examiner? 1 Yes 2 No		Inpatient 2	· · · · · ·			4) (A) (N)			idence 6 Ot		fy)
ono	ling After une	tlon:	27. Manner of Death  ↑≦Natural 5 □ Pending 2 □ Accident investigation		of Injury oth, Day Year)	28b. Time of Injury	M 2	8c. Injun Work	/at <br Yes 2. □		280. Describe	how injury occu	rred	
Division	I or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not to determined	289. Plac	e of Injury - At h	ome, larm, st fy)	reet, lactory	, office				Street and Num wn, State)	ber or Rura	al Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier 15 Certifying P	nysician: To th	e best of my kno	owledge, deat	h occurred	at the tim	ne, date an	nd place,	and due to the	cause(s) and m	nanner as s	stated.
	the Ho iin 24 h the Fu	ledical	(Check only 2 Medical Exa	miner: On the and ma	basis of examination of the state of the sta	ation and/or in				ith occur	red at the time,			
	or distriction	Σ	29b. Signature and title of certifier						number 0			29d. Date sign	ed (Month,	
7	1		30. Name and address of person who	completed cau	use of death (Ite				508 abre	165	SIER	0		1 200 7
-			70.11	veolere	an	4	Bal	lim	ne.	/	40	2/2/	5	
· ·	Sta Regist		31. Date liled (Month, Day, Year)	3 0 9 20	Registrar's Son	m 23a) (Type, ature	de so	med						

ORIGINAL

			rieds	State of Maryland				ental Hygien	_	
			For State Registrar	Otate of Marytan		ificate of D		Reg. N	ZUUL	03492
	Physici		1. Decedent's Name (First, Middle,	Ha Collier			- Constitution of the Cons	2. Date of Death	ay Zie, Zizi	3. Time of Death 4 2:40 PM
	/Medic Examin		4a. Fecility Name (If not institution, Saint Joseph	give street and number) h Medical Cen		4b. City, Town, or t	ocation of Death		c. County of Death Bal	timore
8	Funeral Director		214-40-5874	S. Sex 7. Age (In yrs. It		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea) June 19 19	9. Birth	nplace (State or Foreign untry) 1/10 Y ANICL
	Maryland f show	lor	Usual Residence of Decedent  10a. State  10b. County  A  A  A  A  A  A  A  A  A  A  A  A  A	10c. City	OVALILO	ation		<u></u>		10d. Inside City Limits 1 ☐ Yes 2 🗷 No
	death with the Maryland rms 23a or 28a-f show	Funeral Director	10e. Street and Number	Harloed Rd A	of C	10f. Zip Code	34	10g. C	itizen of What Co	untry?
036		by	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12/ Was Decedent Ever in V.s Armed Forces? 1   Yes 2 10/No If Yes, Give Year or Dates:		as Decedent of His Yes, specify Cuban  Yes 2 No	panic Origin? (Spec , Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race · Amer Black, White Specify:	
Maryland 21215-0036	within 72 hours after iene. iene. r then "natural", or Ite	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4or 5+)	16a. Deceder (Give kir life. DO	nt's Usual Occupation of work done du ONOT use retired)	ion iring most of workin	g 16b.	Kind of Business/I	Dallimot o
land 2	uld be filed a Aental Hygie rked other tic event, ti	To Be Co	17. Father's Name (First, Middle, La WARRIN V.		Ngis	typia 19	18. Mother's Name	(First, Middle, Maide	n Sumame)	7
	1 and 2 should Health and Men em 27 is marke		19a. Informant's Name/Relationshi	Ollier JR	2611 1	with Hil	1 Ave AA	Route Number, City	more M	D 21234
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3  1 ■ Other (Spe	B □Removal from State ce ecify) cell	W Call	con or other place,	me 200	10 Ba	ocation - City or T	MD.
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76007	tificate be executed ig physician and as the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):					3,
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□E	ctopic pregnancy Other (specify)			23d. Date of delin	very Day Year
<u>α</u>	w requires that s been signed be should be deta	ed by Ph	Part II. Other significant condition	s contributing to death but not resu	ulting in the und	erlying cause giver	in Part I.		11	the cause of death?
al Records,	: The law recate has been page 2 sho	Completed						24a. Was an autopsy performed? 1 Yes 2 N	prior to c death?	opsy findings available ompletion of cause of 2 No
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospitaf:	Terms -	Other	26. Place of Death		77.7	110-0
Division of	Attending Physician: r death. ector: After this certific by the funeral director.	atlon: To	1 Yes 2 X No  27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury a	at 2	e 5 🗌 Residence 3d. Describe how inju		ify)
Divis	To the Hospital or Attending Phwithin 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral.	Certification:	3 Suicide 6 Could no determin		me, farm, stree	t, factory, office	2	Bf. Location (Street a City or Town, Stat		ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction Completely filled in the Funeral Direction of the Funer	Medical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of my know xaminer: On the basis of examinati and manner stated.	wledge, death of ion and/or inve	occurred at the time stigation, in my opin	, date and place, and nion, death occurre	nd due to the cause(s d at the time, date ar	s) and manner as nd place, and due	stated, to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier	ma	7	29c. License	number 3263		ate signed (Month	
	10		30. Name and address of person w			int)				ı
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture			Maryland	1 = 1 = 4 4	
	Registi	ar	FFR 0 9 2	2004 Janewa	6	Ann.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ebruary ioner. 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death VIA 1306

**Physician** /Medical **Examiner Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If item 27 is marked other than "naturel; or itema 23a or 28a-f show any injury or other traumatic event. It a Marieral or itema 23a or 28a-f show Baltimore, Maryland 21215-0036

Physician /Medical Examiner

the attending physician and After this certificate has been signed by the atter funeral director, page 2 should be detached for Hospitel or Attending

Arrold Crippen

۵ Completed Be ပ Examine by Physician/Medical Completed Be 2 Certification; Director: within 24 hours of To the Funerei To the Fune completely f

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death

9 Unknown

1 ☐ Yes 2 Z No

1. Natural

2 Accident

3 Suicide

4 T Homicide

29a. Certifier (Check only one) 750 MD

State Registrar

3. Time of Death 12:45 PM If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Days Mary - 52 100M 20 F Hours -5a Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Hes 2 No Baltimore NIA Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21285 eminole Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Masori XVIS. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 0 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) a 21. Signature of Maeral Service Uce 22. Name and Address of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final rostale NZYKS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

24a. Was an autopsy performed? Yes 2 No 1 Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Day

Year

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

N. Eutaw St

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 38 Hospice

31. Date filed (Month, Day, Year) 2004 9

6 ☐ Could not be determined

32. Registrar's Signature

the

			For State Registrar	State of Maryland	d / Depa		ealth and N	Mental Hygie	ne 200	4 03494			
	Physici /Medic	al	Decedent's Name (First, Middle, Last)	Joseph	Con	CA	Location of Death	2. Date of Death Month February	Day 4 Year 20	DY 10 /M			
	Examin	er	4a. Facility Name (If not institution, give stre Mercy Medical Cent	er		Balti	imore Cit	ty	N/A	1			
	Funeral Director		5. Social Security Number  212-30-9734  Usuel Residence of Decedent	7. Age (In yrs. In 70	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) June 15,		inthplace (State or Foreign Country)District Columbia			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-f ahow amportant: If item 27 is marked other than "natural, or items 23a or 28a-f ahow appringly or other traumatic avent, the Medical Examinat must be triuitled at ance.	Director	10a. State 10b. County  Maryland Balti 10e. Street and Number	more	, Town or Lo	10f. Zip Code	Dunc 2122		. Citizen of What C				
030	ours after dealing iral, or items 234	by Funeral	7621 South Bend F  11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	ļ li	Vas Decedent of His f Yes, specify Cubar □ Yes 2\square No	pecify Yes or No-	United S  14. Race - An Black, Wh  Specify:	nerican Indian,				
21215-0036	thin 72 ho e. em "natu Medical	Completed	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)		(Give	lent's Usual Occupa kind of work done di DO NOT use retired)	uring most of worl		b. Kind of Busines	s/Industry			
nd Zi	al Hygien al Hygien d other th	Be Con	12 Years 17. Father's Name (First, Middle, Last)			Machinist		Lever Bros. Corp.  ame (First, Middle, Maiden Sumame)					
Maryland	should band Ments s marked	으	Charles Comegys, 19a. Informant's Name/Relationship (Type					ral Route Number, C	Mary Agnes Klaus  Route Number, City or Town, State, Zip Code)				
re, M	s 1 and 2 f Health a item 27 is other trai		Mr. Joseph J. Comeo	20b. P	lace of Dispo	mphony Wo sition (Name of natory or other place	- 1	-	c. Location - City o				
Baitimore,	permit. Page Department of Important: If any injury or once.		14 Donation 5 Other (Specify)  21. Signature of Fuveral Services of Pacific Dundalk, Inc.  22. Name and Address of Facility  Duda-Ruck Funeral Home of Dundalk, Inc.										
	Physician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):										
68/6U,	cate be executed bhysician and the burial-transit	dical Examiner	cause their understanding of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						11			
P.O. Box 6	that the death certificate to the by the attending physical betached for use as the total the the total th	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	Ideath 3	Ectopic pregnancy Other (specify)	-		23d. Date of d Month	elivery Day Year			
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contri Eval stage Rev	buting to death but not resu	_	nderlying cause give	n in Part I.	23e. Did toba		to the cause of death?  Probably 4 known			
of Vital Records,	The ate h page	Completed by	MASCULAR disu	ose, dial	neter'	mellil	rus	24a. Was an autopsy performe	d?/ prior to	autopsy findings available o completion of cause of essential sections of cause of essential sections are sections.			
ī	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?			la.		ath (Check only one)					
1	Physic this corral dire	2	1 ☐ Yes 2 No	pital: 1 patient 2			4   Nursing H	lome 5 Residence		ecify)			
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death  1 Natural 5 Pending investigation investigation 6 Could not be determined	28a. D te of Injury (Month, Day Year) 28e. Place of Injury - At ho		Work M 1□Y	at ? ∕es 2 □ No	28d. Describe how	et and Number or i	Rural Route Number,			
á	Hospital or I	<u></u>	29a. Certifying Physic	building, etc. (Specify ian: To the best of my kno	wledge, death	n occurred at the tim	e, date and place	City or Town,	se(s) and manner	as stated.			
	Ho Ho	edic	(Check only 2 Medical Exemine one)	<ul> <li>On the basis of examina and manner stated.</li> </ul>	tion and/or in	vestigation, in my op	oinion, death occu	irred at the time, date	and place, and di	ue to the cause(s)			
	To the To the complete	Me	29b. Signature and title of certifier	U)		29c. License <b>D</b> 3			Februa				
	4		30. Name and address of person who com	pleted cause of death (Item	23a) (Type,	Print Place	Boet	o mine M	P 212	02			
	St: Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	Angel.	3 -						

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 03495 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) EBRUARY Day ZZZZ 4 **Physician** 1:30 PM Wyonia Calvarese /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Baltimore Saint Joseph Medical OWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 16, 1927 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2XF Pennsylvania 212-22-6155 76 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Baltimore Glen Arm Maryland Direct 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 11630 Glen Arm Road Apt LO4 21057 U.S.A. by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 □Yes 2 □No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then any injury or other traumatic avent. Elementary/Secondary (0-12) College (1-4or 5+) Substance Abuse Counselor Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gladys Dove ပ္ William Winegard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21057 Benjamin L. Calvarese Husband 11630 Glen Arm Road, Apt LO4, Glen Arm, Maryland 20b. Place of Disposition (Name of Dulaney Valley Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 VBurial 2 Cremation 3 Removal from State 2-11-2004 Timonium Maryland 21. Sanature Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 once. any 1050 York Road of Haga-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEMORRHAGIC STROKE HOURS Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examiner certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2) 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 > npatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DØØ59711 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 INDA ADLER. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 M. D 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 9 2004 Angely & Registrar

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		•	For State Registrar	orato or many ran	Certificate of			leg. No.	004	03	+96
	Physici	an	1. Decedent's Name (First, Middle, Las	1)			Date of Dea Month	Day	Year	3. Time of	Death P M
>	/Medic	al	4a. Facility Name (If not institution, give	street and number)	4h City Town	or Location of Death	JAN	30 4c. Cour	2001	8:47	Į M
	Examin	er	University of Maryle		D.	Himore			NA		
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year	9. Birthpl	ece (State o	r Foreign
ķ.	Director		Usual Residence of Decedent	J.W. 2631	J dame TIS.		Nov. 11	, 1951	1919	ry war	
	nyland how		10a. State 10b. County	10c. C	ty, Town or Location	11:110			10	od. Inside Ci	
	8a-fs	Director	Moryland Balt	more	Owings	TVUIP		10g. Citizen o	4 Mhat Caus	1 ☑Yes	2   NO
	72 hours after death with the Maryland natural; or Items 23a or 28a-f ahow ilical Ezanta at must be notified at		8705 Groffs	Mill Drive	10f. Zip Code	21117		log. Citizeri c	USA		
	er dea	Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No	J.S. 13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. R	ace - America lack, White,		
920	urs aft	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Spec	city: 15 W	CF-	
21215-0036	72 hours "natural"	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Usual Occu (Give kind of work done	during most of work	ing	16b. Kind of	Business/Inc	lustry	,
121	within ene. than	jumo	Elementary/Secondary (0-12)	College (1-4or 5+)	Addictions C	purselor		Mary	tras	rioce	
1d 2	othe	Be Co	17. Father's Name (First, Middle, Last)	1.		18. Mother's Nam	2.4	Maiden Sum	ame)		
ylar		ToE	Kudolph Cos	tin		Elizab					21117
Maryland	12 sh h and 7 Is m treum	1. 18	19a. Informant's Name/Relationship (7) Benton Cohen	ype, Print) -husband	19b. Mailing Address (Street	and Number or Rur	nve C	r, City or Tow	n, State, Zip Mill	Code) Z	rland
	of Health of Health fitem 27		20a. Method of Disposition		Place of Disposition (Name of cemetery, crematory or other pla		Date	20c. Location	n - City or To	wn, State	1
altimore,		1	1 🗹 Burial 2 □ Cremation 3 □  14 □ Donation 5 □ Other (Specify	Hemoval from State	oshell	26	104	Baltin	or, M	arylan	a
Balt	permit. Pag Deptrement Importent: any injury conce		21. Signature of Funeral Service Licen	see Lev	22. Name and Address	ess of Facility A	Ker Cha	timore,	Croman	8 8	6.F.A.
	ž.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea	th. Do not enter the mode of dy	ng, such as cardiac			1	Approximate Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	a. Intracr	anial Idemor	rhage				Onset and I	Death
Н	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	)				16000	Vita en
	*	er	Sequentially list conditions, if any, leading to immediate	b. Due to (ur as a conse	quefice of).					10.15	61
	nd nd transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
760,	e be executed sicien and e burial-transit	cal Ex	resulting its death) cast	Due to (or as a conse	quence of);						1.
687	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit			d							
Box	th cert lending r use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	nancy at death = 3 DEctopic pregnanc	:y			Date of delive		rear
	the att	/sici	in the past 12 months? 1 □ Yes 2 ☑ No. 9 □ Unknown	4□Pregnant at time of 9□ Unknown	death 5 Other (specify)			'	AIOHILI	Day	001
, P.O.	res that the de signed by the a be detached f		Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying cause gi	ven in Part I.	23e. Did to	bacco use co	ontribute to th	e cause of d	leath?
of Vital Records,	w requires been sign should be	ed by					1 🗆 Y	es 2□No	3 🗌 Prob	ably 4 🖼	Inknown
eco	law requias been	Completed					24a. Was a autop	an 241	b. Were autor	psy findings apletion of c	available ause of
al R	sician: The law scertificate has b irector, page 2 s						perfor 1 ☐ Yes	2 200	death?	2 🗆 No	
<u> </u>	Physician: this certificated ral director, I	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: Inpatient 2	□ ER/Outpatient 3□ DOA Ot	26. Place of Deal	n <i>(Check only or</i> ome 5 ☐ Resid		other (Specify	<i>(</i> )	
J Of	ding Phys I. After this funeral di	n: T	27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wo		28d. Describe h			,	
Division	Attending or death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1	]Yes 2□No	204 Leasting /S	Named and Alexandria		I Paula Mum	has
Divi	after of Direction by	Certification:	4 Homicide determined	building, etc. (Spec	nome, farm, street, factory, office ify)		28f. Location (S City or Tow		IIDer or Hura	I MODIO NUM	Der,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		(Check only 2 Medical Exam	niner: On the basis of examin	towledge, death occurred at the treatment and/or investigation, in my						)
	o the h thin 24 o the h	Medical	29b. Signature and title of certifier	and manner stated.	29c. Licen	se number	- 2	29d. Date sig	ned (Month, I	Day, Year)	
	_		> Sheller	RESIDENT 24	WECKEN G	14591		FEB	0.2	2004	
	10			completed cause of death (ite	om 23a) (Type, Print)					,	
TP.			GOPIL GUPTA  31. Date filed (Month, Day, Year)	27 S. G. 32. Registrar's Sign	REZME 5T	BALTIMO	RE MI	> 217	201		
	Sta Regist	ate rar	FER A 9 20	194 19-020	De Ande						

			For State	State	of Marylan	d / Dep	artment o	of Health a	and M	lental H			04	03497
			Registrar  1. Decedent's Name (First, Middle	, Last)			Timeate	or Death		2. Date of	Reg. N Death	0.		3. Time of Death
	Physicia	_	locoph	Ц	Ca	llahar	n			Febru		3, 200	Year 04	4:00 A M
7	/Medic Examin	1	Joseph 4a. Facility Name (If not institution			LILIGITAI		wn, or Location	of Death	1. 00. 0		c. County o		
			Gilchrist C	enter			To	wson				Bal	timo	re
4	Funeral		5. Social Security Number	6. Sex 1 X M 2 □ F	7. Age (In yrs.		) If Under 1 Y Months D	rear If Under Pays Hours	24 Hrs. Min.	8. Date of (Month, Dec.	Birth Day, Yea	2000	Coun	lace (State or Foreign try)
ig <sup>2</sup>	Director		214-18-2700		81	Yrs.				Dec.	24,	1922	Mar	yland
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation.						1	0d. Inside City Limits
	Mary	ō	Maryland Balti	more		Towson	n							1 □ Yes 2 No
	7.28a	Director	10e. Street and Number	mor c		101150	10f. Zip Co	ode			10g. C	itizen of W	hat Cour	try?
	deeth with the Maryland ms 23a or 28a-f show r must be notified at	a D	8606 Drumwood	Road			21	286				U.S.	Α.	
	e u	Funeral	11. Marital Status	12. Was De	cedent Ever in U orces?	.S. 13.	Was Deceden	t of Hispanic Ori Cuban, Mexical	igin? (Sp n, Puerto	ecify Yes or Rican, etc.)	No-	14. Race Black	- America , White,	
0	hours efter tural', or Ita	by Fu	1 Never Married 2 Marr	ied 1 X Yes	: 2 □ No Bive 1944-1 Date 1:944-1	946	1 ☐ Yes 2 💢	No Specify:				Specify:	1.He	:+0
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7 7	r the	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	Su	perviso	r						ing Co.
and	e filed within 72 h al Hygiene. I other then "natu	Bec	17. Father's Name (First, Middle,	Last)					er's Nam	e (First, Mide				
<u>a</u>	2 should be and Mental le marked o	70 E	Joseph	С.	Callahar				rgar		Cecil		'Bri	
Mar)	s 1 and 2 should be filed within 72 hours effer deeth with the Marylan of Health and Mental Hygiene a feet or Itams 23a or 28a-f show then 21 a marked other then "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exacting maintee incititied at		19a. Informant's Name/Relations	hip (Type, Print)										Code) 21043
≥ ~	and lealth m 27 her tr		Joellen Callaha 20a, Method of Disposition	n Daug	hter		Old Wo	odstock		e Ell Date		t Cit		aryland
0	ges 1 If of H If Ite or of		1 X Burial 2 ☐ Cremation		n State Mar	vland	Vetera	ns Cem.	2-9-	2004				s, Maryland
Баппро	t. Pa rtmer rtant: njury		21. Signature of Funeral Service	1 1	Gá	arriso	n Fores	T i						
n D	permit. Pages Department of I Important: If Its eny injury or of		Tour D	Hagru				rk Road		OWSON,				ome, Inc. 204
	5 DOM:		23a. Part1. Enter the disease, or shock, or heart failure. List	comp ic sions tha	t caused the deat				-0.0			S-1100	75-33	Approximate Interval Between
	Physician		Immediate Cause (Final	only one pluse or	each line.	HAZE	10-11	el dis	eas	e				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due t	o (or as a conseq	juence of):	, 02-7-1						-	man of
	Examiner		Coquentially list conditions	b. 1-4	y per-	len.	cin							years
	₽ ≒	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due t	o (or is a conseq		elli	1						V
	ecute and Ftrans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due t	o (or as a consec	· · ·				<u>-</u>				year
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	~		30. Name and address of person	who completed ca	use o' death (Ite	m 23a) (Type	Print)	7 ~:			1.		/	2004
-	4		W.A.Role	1 G31	mc 62	701 N	-Clim	le St	· P	rulto	· M	1 21	204	C
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	Regist	rar	FEB 0 9 a	TUU.	7	٠ شو								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 03498 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Catherine February 2, 2004 6:05 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Laurel Regional Hospital Prince George's Laurel If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🗙 F 401-07-9859 89 June 18, 1914 Kentucky Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 X Yes 2 No Prince George's Laurel MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 339 Laurel Avenue 20707 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② ANO If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3√EWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Jefferson Springgate Ida Wilkerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas DeVore/Son 339 Laurel Avenue, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ivy Hill Cemetery Feb. 6, 2004 Laurel, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Ligensee M00160 313 Talbott Avenue, Laurel, MD 20707 seuce Klandle Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septicemia 3 Days Due to (or as a consequence of): Pneumonia 1 Month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Acute Renal Failure 1 Month Due to (or as a consequence of): Congestive Heart Failure Month IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2XXNo Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Type II Diabetes 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🔯 No 1 Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 K Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43237 February 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

requires that the death certificate be executed use as the burial-transit attending physician Division of Vital Records, P.O. Box 68760 ate has been signed by the atte page 2 should be detached for or Attending Physician: the funeral dir this within 24 hours after death. To the Funerel Director: A filled in by

**Physician** 

/Medical

Examiner

**Funeral** 

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Physician

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

0 9 2004

31. Date filed (Month, Day, Year)

Paul Armstrong, M.D.

32. Registrar's Signature

14201 Laurel Park Drive, #102, Laurel, MD 20707

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:15 PM HARRIETT LEBHERZ DONOVAN FEBRUARY 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Yrs. Director 214-10-3021 86 Rhode Island Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Directo Maryland Frederick Frederick 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 21701 U.S.A. itams 23a 512 Fairview Avenue Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or ital any injury or other traumatic svent, it a Medical Evant and 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry National Institute Elementary/Secondary (0-12) College (1-4or 5+) Secretary of Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Behney William B. Lebherz, Sr. Harriet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5640 Singletree Drive, Frederick, Maryland, 21703 Harriett A. MacInnes/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Smithsburg Crematory 02/07/2004 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 106 East Church Street once. Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2 4 clay **Physician** Neumon /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed **burial-transit** and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 | Fetal death 3 Ectopic pregnancy ö in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 🗓 ¥6 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 des 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No 1 Yes 2 No Attending Physicien: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 propatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DDA ို this filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide after within 24 hours a To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature an stitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 cause of death (Item 23a) (Type, Print) 14 32. Registrar's Signature 31. Date filed (Month, Day,

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